THE HEALTH of DEVON in 1966

The Annual Report of the
County Medical Officer and
Principal School Medical Officer

COUNTY COUNCIL OF DEVON

ANNUAL REPORT

of the

COUNTY MEDICAL OFFICER

and the

PRINCIPAL SCHOOL MEDICAL OFFICER

FOR THE YEAR 1966

DEVON HEALTH COMMITTEE

as at 31st December, 1966

Health Committee

Chairman: †Rev. J. W. Timms.

Vice-Chairman: ‡Mrs. M. Owen.

Chairman of the Council (*ex officio*)

Vice-Chairman of the Council (*ex officio*)

‖Mrs. Adams	Mr. Hillard	Mrs. Patt
Mr. Attenborough	Major Jackson	*Mrs. Perkin
Mr. Daymond	Mr. Kerr	Mr. Pollard
Mr. Disney	Mr. Lee	Mr. Prowse
Mr. Franks	Mr. MacMullen	Mrs. Ratcliffe
Mrs. Gibbens	Mr. Marshall	Capt. G. H. Roberts
Sir G. C. Hayter-Hames	Mrs. Park	Mr. Thomas

Nominated by the following bodies:

Community Council of Devon—Dr. A. Robinson Thomas

Devon Branch, British Red Cross Society—Capt. G. T. Millett, C.B.E.

Devon Branch, St. John Ambulance Association—§Major T. W. Gracey.

Devon and Exeter Local Dental Association—Mr. G. Pendlebury.

Devon and Exeter Local Medical Committee—Dr. R. M. S. McConaghey, Dr. G. C. C. MacVicker.

Devon and Exeter Pharmaceutical Committee—Mr. H. Jarvis Graves.

Executive Council for Devon and Exeter—Mr. A. D. J. Harvey.

Women's Voluntary Service for Civil Defence—Mrs. R. Croft.

§ Chairman of Ambulance, † Appointments and General Purposes, ‡ Adult Health, ‖ Child Health and * Nursing sub-committees.

School Health Service Sub-Committee of the Education Committee

Chairman: Mrs. F. Hiley

Vice-Chairman: Mrs. A. S. Ratcliffe

Chairman and Vice-Chairman of the Council (*ex officio*)

Chairman and Vice-Chairman of the Education Committee (*ex-officio*)

Mr. Crook	Mr. Lee	Mr. Pridham
Miss Hancock	Mrs. Owen	Dr. Vanstone
Mrs. Woodcock	Mrs. Perkin	Mr. Vinnicombe
	Prof. S. H. Watkins	

STANDING SUB-COMMITTEES OF THE DEVON HEALTH COMMITTEE

Adult Health Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in respect of the following services:—

Mental health (other than for children) and the care and after-care of mentally disordered adults, including provision of adult training centres.

Registration of mental nursing homes.

Care and after-care of persons suffering from physical illness (including provision for tuberculosis, occupational therapy, and home teaching services and the chiropody service).

To visit, inspect and manage adult training centres and workshops, including any hostel provided for such centres, and to deal with all matters connected therewith within the annual budget to be allocated by the Health Committee, provided that the Health Committee may, with the approval of the Finance Committee, modify such annual budget, as may be necessary from time to time in order to meet special items as they arise.

Ambulance Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the ambulance service.

Child Health Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the following services:—

Care of young children.

Vaccination and immunisation.

Registration of day nurseries and child minders.

Care and training of mentally subnormal children of school age.

Registration of homes for mentally disordered in relation to homes for subnormal children.

To visit, inspect and manage junior training centres, including any hostel provided for such centres.

Nursing Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the following services:—

Care of mothers and infants.

Midwifery.

Health visiting.

Home nursing.

Domestic help.

Registration of nursing homes, except mental nursing homes.

Appointments and General Purposes Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the following:—

Staffing matters (including the appointment of staff not delegated to the County Medical Officer).

Provision of clinics and health centres and their maintenance.

Health Education.

Supply of Water.

Disposal of Sewage.

Food and Drugs.

Milk and Dairies.

Any other functions of the Health Committee not specifically referred to any other sub-committee.

Basildon Sub-Committee: To visit, inspect and manage the County Council's home for delicate children. To present annual reports of their stewardship and to report special items to the Health Committee.

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INTRODUCTION

Health Department,
County Hall,
Exeter.

July, 1967.

To: The Chairman, Aldermen and
Members of the Devon County Council.

Mr. Chairman, My Lord, Ladies and Gentlemen,

I have the pleasure of introducing the annual report for 1966, covering my third year of office as your county medical officer and principal school medical officer.

The report gives details of the vital statistics of the area and of the many services provided by the county council's health department for the prevention of illness, promotion of health and the care and after-care of patients in the community.

The vital statistics include one especially welcome "record low". This relates to the perinatal mortality rate which is calculated from a summation of stillbirths and deaths in the first week of life and is generally accepted as an index of the efficiency of the midwifery services. In the county of Devon the perinatal rate reached the remarkably low level of 21.0 per thousand births. The corresponding figure for England and Wales is 26.3, which is also a record. As the midwifery service is spread over all three branches of the National Health Service, i.e. hospitals, general practitioners and county midwives, the achievement gives scant support to those pessimistic critics who are constantly forecasting the imminent breakdown of the service.

The pattern of midwifery care is nevertheless changing rapidly. An increasing proportion of mothers are being confined in hospitals, many of them being discharged after only a few days to be nursed at home by the district midwives. This has resulted in fewer deliveries by our midwives but a marked increase in time spent on maternity nursing. If this trend continues many of the rural midwives will be having insufficient clinical experience to maintain their skill. This would seriously affect the attractiveness of the job, render recruiting difficult, and reduce the efficiency of the service.

One possible solution would be for midwives to accompany their patients into the local hospital and be responsible for the delivery there. This would ensure continuity of attendance, assist the hard-pressed hospitals and provide greater "job satisfaction" for the midwives. The health committee has approved this procedure in principle but it must be emphasised that it can only be put into operation in any area with the full consent and agreement both of the hospital authority and the local midwives. This midwifery situation demonstrates how the division of the National Health Service into three separately administered branches sometimes makes adjustment to changing conditions difficult, but fortunately not impossible, provided there is mutual confidence and goodwill.

Another example of "blurring the edges" between different branches of the service is provided by the efforts made in this county to bring our domiciliary nursing and other supporting services into closer relationship with the work of general practitioners. At the present time we have six health centres in operation in which general practitioners are working harmoniously alongside county council staff. Several more health centres are on the way and it is possible that within the next six or seven years about one-third of the general practitioners in the county area will be practising from health centres. A great deal of patient planning, negotiation and hard work will be required to achieve this degree of development but I am personally confident that, with the continued goodwill of the county council, the Executive Council and the doctors, this new era of medical care can be safely launched with lasting benefits to the community.

Another highlight of the year's work deserving of special mention in this introduction is the special survey carried out in Paignton with the co-operation of Dr. J. F. Burdon, a local general practitioner. One of the aims of this survey was to determine the practicability of retirement clinics. Dr. Burdon's account of the progress made so far in this pilot scheme suggests that there is a great deal of undiagnosed and untreated illness in elderly persons, but as the number examined so far is only about one hundred, it would be premature and unwise to draw any hard and fast conclusions. What one can say with reasonable certainty is that the findings were sufficient to justify the health committee in its decision to approve of six retirement clinics being started in the county area during the current financial year.

Other services for the elderly continue to grow in order to meet the ever-increasing need. The health visiting, home help and chiropody services in particular have expanded considerably in their work for the elderly. In the case of the chiropody service the growth has not kept pace with the increased demand, and unless there is further expansion in the near future, an increasing number of elderly people will suffer pain, hardship and isolation.

Good progress continues to be made in the implementation of the 1959 Mental Health Act. The aim of the mental health services provided by this department is to give advice, support and where necessary training, for all children and adults who require it by reason of mental handicap or illness. In addition to our growing staff of mental health social workers and occupational therapists, we now have a network of both junior and adult training centres with a total accommodation of approximately seven hundred persons. One is particularly happy to report the opening of the Doyle adult training centre at Exmouth. Named after my predecessor, the late Dr. William John Doyle, this large purpose-built centre must be one of the finest in the country and is already doing magnificent work for a wide variety of handicapped men and women.

The rapid strides made by the department in the development of its services is due to the unwavering support of the health committee and the devotion, loyalty and energy of the staff of my department, to whom I am greatly indebted.

J. LYONS,

County Medical Officer and
Principal School Medical Officer.

STAFF OF THE HEALTH DEPARTMENT

County Medical Officer and Principal School Medical Officer	J. Lyons, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.
Deputy County Medical Officer and Deputy Principal School Medical Officer	D. S. Parken, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H., D.P.H.
Senior Medical Officer for Maternal Health and Nursing	F. Gloria Richards, M.R.C.S., L.R.C.P., D.(OBST.), R.C.O.G.
Senior Medical Officer for Child Health	D. O. McKnight, M.B., B.S., D.C.H., D.P.H.
Senior Medical Officer for Adult Health	J. A. Theobald, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.
Senior Assistant County Medical Officer	D. Cullen, M.B., B.S., L.R.C.P., M.R.C.S., D.P.H.
County Superintendent of Nursing and Supervisor of Midwives	Miss G. Heather, S.R.N., S.C.M., H.V.C.
Superintendent Health Visitor	Miss E. L. Hunter, S.R.N., C.M.B. (Pt. I), H.V.C.
Health Education Officer	Miss P. O. Davies, R.M., D.H.ED.
County Health Inspector	M. S. Powling, F.A.P.H.I., M.I.P.H.E.
Principal Administrative Officer ..	J. Cooke
Chief Clerk	H. T. Baldwyn
County Ambulance Officer	R. P. Selley, D.P.A., F.I.A.O.
Home Help Organiser	G. P. Brooks, D.P.A., D.S.A.
Principal Social Worker	L. H. Jenkins, D.S.S., M.H.CFR I.
Senior Occupational Therapist ..	Miss M. M. Keily, M.A.O.T.
Chief Chiropodist	W. Beedle, M.Ch.S., R.M.A.
Senior Workshop Manager	T. O. Hughes, D.M.A.
Administrative Officers:	
Maternal Health & Nursing Section	K. G. Baker
Adult Health Section	R. H. G. Gibson
Child Health Section	W. H. Nickels
General Health Section	R. J. Hollett, D.P.A.

Medical Officers

L. G. Anderson, M.D., Ch.B., D.P.H.
H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H.
R. C. MacLeod, M.D., D.P.H., D.T.M. & H.
D. K. MacTaggart, M.A., M.B., Ch.B., D.P.H.
R. B. Walker, M.R.C.S., L.R.C.P., D.P.H. (resigned 31.10.66)
J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H.
E. Williams, M.R.C.S., L.R.C.P., D.P.H.

} "mixed" appointments

J. Allott, M.B., Ch.B., D.P.H.
N. E. R. Archer, M.A., D.M., B.Ch., D.P.H.
R. H. Browning, M.B., B.S. (resigned 31.10.66)
M. E. Budding, B.Sc., M.B., Ch.B., D.P.H.
W. E. Denbow, B.Sc., M.R.C.S., L.R.C.P., D.P.H.
M. J. Dunn, M.B., Ch.B.
L. Solomon, B.A., M.B., B.Ch., B.A.O., L.M., D.P.H., D.C.H.
P. W. Tait, M.B., Ch.B. (part-time)
W. Burgess, L.R.C.P., M.R.C.S., M.B., B.S., D.C.H., M.R.C.P., M.D. (part-time)
S. C. Candler, M.B., Ch.B., M.R.C.S., L.R.C.P. (part-time)
E. A. Chalk, B.A., B.M., B.Ch (part-time)
J. M. MacTaggart, M.B., Ch.B., D.P.H. (part-time)
E. A. Forsyth, M.B., Ch.B., D.P.H. (part-time)
S. M. Gould, M.B., Ch.B. (part-time from 6.6.66)
J. M. Hall, M.B., B.S., D.P.H. (part-time from 1.8.66)
J. M. Shields, M.B., B.S., M.R.C.S., L.R.C.P., D.(OBST.), R.C.O.G. (from 31.5.66)

School Ophthalmic Surgeons*

A. M. Barnett, M.A., B.A., M.R.C.S., L.R.C.P., D.O.
R. C. Chaturvedi, M.B., B.S., D.O.
A. J. A. McCormick, M.B., Ch.B., F.R.C.S., D.O.M.S.
G. Searle, M.R.C.S., L.R.C.P., D.O.

Chest Physicians*

G. E. Adkins, M.B., B.CHIR.
W. E. B. Lloyd, M.R.C.S., L.R.C.P., D.P.H.
B. R. Hillis, M.D., M.B., Ch.B., F.R.F.P.S., M.R.C.P.
J. J. Y. Dawson, M.C., M.D., M.R.C.P.

Psychiatrists, Child Guidance*

H. S. Gaussen, M.R.C.S., L.R.C.P.
C. J. Wardle, M.D., B.S., M.R.C.S., L.R.C.P., D.P.M.

*On staff of the Regional Hospital Board.

DENTAL SERVICE

Chief County Dental Officer and Principal School Dental Officer .. J. D. Sykes, L.D.S.

County Orthodontist .. .. .. J. D. W. Barnett, B.D.S., D.ORTH., R.C.S. (from 1.5.66)

Dental Officers (full-time):

G. W. B. Bateman, L.D.S., R.C.S. (from 10.1.66)
Kathleen Billings, B.D.S. (from 31.1.66)
G. H. S. Clarke, L.D.S. (retired 31.12.66)
G. J. Derbyshire, L.D.S.
J. L. Dickson, L.D.S., R.F.P.S.
H. W. Gibbs, L.D.S., R.C.S.
H. G. Hobdell, L.D.S., R.C.S. (from 1.5.66)
V. G. Holdsworth, L.D.S., R.C.S. (deceased 20.1.66)
J. F. Hunt, L.D.S., R.C.S.
F. A. Pearse, O.B.E., L.D.S., R.C.S.
C. T. Pomeroy, L.D.S., R.C.S.
A. Shipley, B.D.S.
J. Smith, L.D.S. (resigned 24.11.66)
K. P. Smith, L.D.S., R.C.S.
J. W. Steer, L.D.S., R.C.S.
C. N. van Rijswijk, B.Ch.D.
J. K. Vowles, B.D.S.
F. M. Warren, B.D.S., L.D.S., R.C.S.
H. D. Williams, L.D.S., R.C.S.

Dental Auxiliaries:

Miss M. I. Sowden (resigned 31.8.66)
Miss D. R. Williams (from 1.9.66)

Dental Hygienist:

Miss P. H. Turnage

PART I

VITAL STATISTICS

Area and Population

Births

Deaths

VITAL STATISTICS

Devon is a predominantly rural county but has a concentration of almost 100,000 in the Torbay area, where almost one-fifth of the population reside. The remainder of the county, apart from relatively small urban areas, consists of rural districts which include two large areas of sparsely populated countryside, Dartmoor and the western part of Exmoor. The larger parts of the parishes of Alphington, Pinhoe and Topsham were transferred to the Exeter County Borough Council on the 1st April, 1966, with an approximate population of 9,000.

Area and Population

	Municipal Boroughs and Urban Districts	*Rural Districts*	*Administrative County*
Area (acres)	127,015	1,506,341	1,633,356
Population (estimated mid-1966)	281,600	279,790	561,390

Number of Municipal Boroughs, 10; Urban Districts, 18; Rural Districts, 16; Total, 44.

Statistics are detailed on pages 24 and 46, but the following is both a summary and an outline of the more interesting facts.

Births

Registered live births number 8,179, equivalent to a rate of 17.6 per thousand population. The number of stillbirths registered was 100 corresponding to a rate of 12.08 per thousand total births.

Deaths

The total number of deaths allocated to the administrative county was 8,481 compared with 8,201 in 1965.

Due to the age/sex distribution of the population differing from area to area throughout the county, crude rates although based on actual occurrences fail to provide a useful mortality index. To enable more realistic comparisons of the mortality between different areas to be made, compensating factors are applied to the crude rates. The death rates from all causes for the past six years, adjusted by the appropriate factors, for the aggregates of boroughs and urban districts, rural districts and the administrative county, also the rates for England and Wales, are given below:

Year	Municipal Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1961	12.0	11.2	11.6	11.9
1962	12.1	11.3	11.7	11.9
1963	11.6	11.5	11.7	12.2
1964	10.9	10.1	10.4	11.3
1965	10.3	10.2	10.2	11.5
1966	10.7	10.4	10.6	11.7

Perinatal Mortality

This term is used to describe stillbirths, together with deaths during the first week of life, and the resultant rate expressed per thousand total births. The 1966 rate of 21.02 is a reduction of 2.25 on the 1965 rate.

Infant Mortality

Deaths of infants in the first year of life numbered 145 representing a rate of 17.73 per thousand live births. This figure is an increase on that for 1965.

Causes of Death

	1966	1965
Diseases of heart and circulatory system	3,413	3,414
Cancer and other malignant diseases	1,575	1,520
Vascular lesions of nervous system	1,311	1,307
Diseases of respiratory system (excluding tuberculosis)	877	691
Accidents, suicides, etc.	298	288
Diseases of stomach and digestive system	88	105
Diseases of genito-urinary system	75	105
Tuberculosis	24	25
Other infectious diseases	30	28
Maternal deaths	3	2
All other causes	787	716
Total deaths	8,481	8,201

Principal Causes of Death

The main causes of death remained, in descending order, as in recent years. It is of interest to note that the number of deaths from cancer is still rising, due largely to a sharp increase in deaths from lung cancer.

The relative contributions of the diseases, which accounted for 88.06% of the total mortality, is indicated below.

Percentage Contribution of Total Causes

Main Causes	1961	1962	1963	1964	1965	1966
Malignant Neoplasms	17.22	17.97	17.06	18.98	18.53	18.51
Vascular Lesions of Nervous System	15.78	16.53	16.09	16.08	15.94	15.45
Heart and Circulatory Diseases	40.88	40.32	39.57	39.34	41.63	40.25
Disease of Respiratory System	9.94	9.28	11.60	9.75	8.42	10.34
Accidents, Suicide and Violence	3.43	4.02	3.96	3.68	3.51	3.51

Causes of Death	Sex	All ages	Under 4 weeks	4 weeks and under 1 year	1—	5—	15—	25—	35—	45—	55—	65—	75—
All Causes	M	4,202	60	28	7	12	41	28	70	205	694	1,261	1,795
	F	4,278	34	23	13	6	17	21	50	151	382	996	2,579
1. Tuberculosis—respiratory	M	15	—	—	—	—	—	—	—	1	2	6	6
	F	5	—	—	—	—	—	—	1	—	1	3	—
2. Tuberculosis, other	M	1	—	—	—	—	—	—	—	—	1	—	—
	F	3	—	—	—	—	—	—	—	—	1	1	1
3. Syphilitic disease	M	5	—	—	—	—	—	—	—	—	1	1	3
	F	3	—	—	—	—	—	—	—	—	1	—	2
4. Diphtheria	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
5. Whooping Cough	M	1	—	1	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
6. Meningococcal infections	M	1	—	—	—	—	—	—	—	—	1	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
7. Acute poliomyelitis	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
8. Measles	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
9. Other infective and parasitic diseases	M	8	—	—	—	1	1	1	—	2	—	1	2
	F	12	—	—	1	—	—	—	—	2	3	1	5
10. Malignant neoplasm, stomach	M	110	—	—	—	—	1	—	—	7	27	38	37
	F	53	—	—	—	—	—	—	—	3	9	15	26
11. Malignant neoplasm, lung, bronchus	M	275	—	—	—	—	—	—	6	16	94	116	43
	F	59	—	—	—	—	—	—	3	7	20	17	12
12. Malignant neoplasm, breast	M	2	—	—	—	—	—	—	—	—	1	1	—
	F	145	—	—	—	—	—	1	9	28	29	37	41
13. Malignant neoplasm, uterus	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	69	—	—	—	—	—	1	4	11	15	19	19
14. Other malignant and lymphatic neoplasms	M	426	—	—	1	1	5	2	10	26	80	138	163
	F	395	—	—	1	—	2	7	3	27	63	133	159

15.	Leukaemia, Aleukaemia	M	21	—	1	—	2	—	2	1	1	2	9	3
		F	20	—	—	1	1	—	—	1	2	2	4	9
16.	Diabetes	M	15	—	—	—	—	—	—	1	1	—	6	7
		F	37	—	—	—	—	—	1	—	2	3	19	12
17.	Vascular lesions of nervous system ..	M	531	—	—	—	—	—	1	6	12	67	153	282
		F	780	—	—	—	—	—	1	3	13	48	197	5 8
18.	Coronary disease, angina	M	1059	—	—	—	—	—	4	15	71	210	393	366
		F	718	—	—	—	—	—	—	4	15	76	212	411
19.	Hypertension with heart disease ..	M	50	—	—	—	—	—	—	—	2	10	17	21
		F	75	—	—	—	—	—	—	—	—	8	25	42
20.	Other heart disease	M	456	—	1	—	—	3	—	4	13	39	93	303
		F	665	—	1	—	—	2	1	3	4	22	88	544
21.	Other circulatory disease	M	175	—	—	—	1	—	—	2	7	21	43	101
		F	215	—	—	—	—	—	—	1	4	11	50	149
22.	Influenza	M	50	—	—	—	—	—	—	—	4	4	13	29
		F	54	—	—	—	—	—	—	—	2	5	13	34
23.	Pneumonia	M	196	5	5	1	—	—	—	—	1	14	40	130
		F	231	2	4	3	—	2	—	1	3	4	45	167
24.	Bronchitis	M	211	—	—	—	—	—	—	2	5	40	78	86
		F	59	—	—	—	1	—	—	—	1	4	12	41
25.	Other diseases of respiratory system ..	M	41	—	—	—	—	1	—	2	1	6	9	22
		F	35	—	4	—	—	—	—	3	3	2	6	17
26.	Ulcer of stomach and duodenum ..	M	26	—	—	—	—	—	—	—	—	9	6	11
		F	24	—	—	—	—	—	1	—	1	4	3	15
27.	Gastritis, enteritis and diarrhoea ..	M	15	1	2	—	—	—	—	—	1	2	6	3
		F	23	—	1	1	—	—	—	—	—	—	7	14
28.	Nephritis and nephrosis	M	15	—	—	—	—	2	1	1	1	7	2	1
		F	17	—	—	—	—	2	1	—	1	4	4	5
29.	Hyperplasia of prostate	M	43	—	—	—	—	—	—	—	—	1	11	31
30.	Pregnancy, child birth, abortion ..	F	3	—	—	—	—	1	1	1	—	—	—	—
31.	Congenital malformations	M	32	19	6	—	1	—	—	1	1	1	2	1
		F	14	5	3	2	1	1	—	—	—	—	1	1
32.	Other defined and ill-defined diseases ..	M	272	35	6	1	2	5	2	7	19	34	39	122
		F	417	26	3	2	—	1	2	5	13	31	70	264
33.	Motor Vehicle Accidents	M	47	—	—	1	—	18	5	5	5	4	5	4
		F	19	—	1	1	2	5	2	2	—	1	2	3
34.	All other accidents	M	68	—	6	3	4	3	9	3	4	6	13	17
		F	95	1	4	1	1	—	—	3	3	7	0	65
35.	Suicide	M	35	—	—	—	—	2	1	4	3	10	12	3
		F	30	—	—	—	—	1	1	3	6	8	8	3
36.	Homicide and Operations of War ..	M	1	—	—	—	—	—	—	—	1	—	—	—
		F	3	—	2	—	—	—	1	—	—	—	—	—

Tuberculosis

Deaths From Tuberculosis

Classification	Age Group																Total		Grand Total
	0—		1—		5—		15—		25—		45—		65—		75—				
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Respiratory	—	—	—	—	—	—	—	—	—	1	3	1	6	3	6	—	15	5	20
Non-Respiratory	—	—	—	—	—	—	—	—	—	—	1	1	—	1	—	1	1	3	4
Totals	—	—	—	—	—	—	—	—	—	1	4	2	6	4	6	1	16	8	24

The deaths in this group were one less than in the preceding year. It is imperative that all preventive measures shall continue to be applied diligently, with the ultimate goal of complete eradication.

Infective and Parasitic Diseases (excluding tuberculosis)

There were 30 deaths in this group and once again diphtheria and poliomyelitis are conspicuous by their absence. This is due mainly to the acceptance of immunisation by large numbers of the population.

Cancer

The total, including leukaemia, numbered 1,575, a higher figure than last year. Lung cancer deaths remain a particular cause of concern, since all the available evidence points indisputably to cigarette smoking as the most important single factor in the causation of this disease.

The following table shows the relative contribution to mortality from the separately classified sites.

CANCER DEATHS

Year		Stomach	Lung, Bronchus	Breast	Uterus	Other Malignant and Lymphatic Neoplasms	Leukaemia, Aleukaemia	Total all sites
1961	M.	104	198	1	—	358	21	682
	F.	92	37	123	47	341	22	662
	T.	196	235	124	47	699	43	1,344
1962	M.	103	205	1	—	383	28	720
	F.	85	53	139	59	353	20	709
	T.	188	258	140	59	736	48	1,429
1963	M.	94	241	—	—	411	25	771
	F.	79	51	137	45	341	17	670
	T.	173	292	137	45	752	42	1,441
1964	M.	102	228	1	—	389	22	742
	F.	89	60	134	75	373	26	757
	T.	191	288	135	75	762	48	1,499
1965	M.	109	247	1	—	428	15	800
	F.	70	55	144	54	377	20	720
	T.	179	302	145	54	805	35	1,520
1966	M.	110	275	2	—	426	21	834
	F.	53	59	145	69	395	20	741
	T.	163	334	147	69	821	41	1,575

VASCULAR LESIONS OF THE NERVOUS SYSTEM

Assigned to this group were 1,311 deaths.

HEART AND CIRCULATORY DISEASES

Causing 3,413 deaths, this group carries year by year the highest mortality and accounts for approximately 40.25% of the total causes.

HEART AND OTHER CIRCULATORY DISEASE DEATHS

Year	Coronary disease, angina		Hypertension with heart disease		Other heart disease		Other circulatory disease		Total	
	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate
1961	1,333	1.99	180	0.27	1,282	1.91	395	0.59	3,190	4.76
1962	1,392	2.05	157	0.23	1,279	1.88	379	0.56	3,207	4.72
1963	1,569	2.17	180	0.25	1,254	1.73	339	0.47	3,342	4.61
1964	1,477	1.94	137	0.18	1,161	1.52	332	0.44	3,107	4.08
1965	1,670	1.83	135	0.17	1,201	1.49	408	0.50	3,414	4.24
1966	1,777	2.22	125	0.22	1,121	1.40	390	0.49	3,413	4.26

Deaths from Accidents, Violent Causes, etc.

The total number of deaths over the past six years has tended to fluctuate but this year's figure is higher, due largely to an increase in fatal home accidents which make up the bulk of those classified as "all other accidents".

Year	Motor Vehicle Accidents	All other Accidents	Suicide	Homicide and Operations of War	Total Accidents, Suicide, Homicide
1961	62	142	62	2	268
1962	56	175	79	10	320
1963	63	193	75	3	334
1964	70	141	75	5	291
1965	84	142	59	3	288
1966	66	163	65	4	298

Diseases of the Respiratory System (included Tuberculosis and Lung Cancer)

The 877 deaths assigned to this group excluded those due to bronchitis, pneumonia, and influenza, and involved chiefly the older age groups.

The national death-rate in what is widely known as the "English disease" remains among the highest in Europe. Much could be done to effect control, as smoking and air pollution are contributory factors.

Suicides

		Totals	15-24	25-34	35-44	45-54	55-64	65-74	75 Plus	Incidence rate (Per 1,000 pop.)
Rural districts (pop. 279,790)	M	15	—	—	3	—	4	6	2	
	F	7	—	—	—	2	5	—	—	
Total		22	—	—	3	2	9	6	2	0.079
Urban districts (Pop. 281,600)	M	20	2	1	1	3	6	6	1	
	F	23	1	1	3	4	3	8	3	
Total		43	3	2	4	7	9	14	4	0.152
Admin. County Rural & urban districts (Pop. 561,390)	M	35	2	1	4	3	10	12	3	
	F	30	1	1	3	6	8	8	3	
Total		65	3	2	7	9	18	20	6	0.116

Districts		Popla-tions (Estim'td) Home)	Estimated Population Aged 65 Years and Over	Births			Infant Deaths		Tuberculosis and Other Infectious Diseases	Cancer & Other Malignant Diseases	Vascular Lesions of Nervous System	Heart and Circulatory System	Respiratory (excluding Tuberculosis)	Stomach & Digestive System	Genito-Urinary	Maternal	All Others	Accident, Suicide, etc.	Total Deaths		
					Rates per 1,000 Population		Under 4 weeks	Under 1 year									16, 31				
				No.	Crude Rate	Cor'd Rate	No.	No.	1-9	10-15	17	18-21	22-25	26-27	28-29	30	32	33-36	No.	Crude Rate	Cor'd Rate
Budleigh Salterton	U.D.	3,810	1,302	36	9 449.	17 .080	—	—	—	15	11	36	8	—	2	—	6	4	82	21 .522	10 .115
Exmouth	U.D.	21,740	4,939	331	15 .225	19 .488	3	4	—	85	81	165	45	9	3	—	58	24	470	21 .619	12 .107
*St. Thomas	R.D.	32,170	4,438	445	13 .833	16 .323	3	6	3	67	53	162	66	8	5	—	45	23	432	13 .397	8 .842
Ottery St. Mary	U.D.	4,800	833	61	12 .708	17 .410	1	1	1	14	8	18	5	1	—	—	5	2	54	11 .250	7 .312
Sidmouth	U.D.	11,460	3,632	105	9 .162	16 .217	3	3	1	46	40	103	19	4	8	1	20	9	251	21 .902	9 .637
*Honiton	M.B.	5,110	681	85	16 .634	17 .965	1	2	—	10	23	24	6	—	2	—	13	1	79	15 .460	8 .657
Seaton	U.D.	3,610	1,088	29	8 .033	11 .487	—	—	—	20	13	32	8	—	—	—	1	3	77	21 .330	9 .812
*Axminster	R.D.	14,890	2,852	188	12 .626	16 .540	3	5	1	39	24	70	18	1	5	—	15	9	182	12 .223	9 .412
Honiton	R.D.	7,160	1,163	112	15 .642	18 .301	—	—	—	22	10	25	4	1	—	—	7	5	74	10 .335	9 .611
Creidton	U.D.	4,880	764	77	15 .779	16 .725	3	3	—	12	14	32	14	—	—	—	9	4	85	17 .418	15 .502
Crediton	R.D.	9,840	1,566	156	15 .851	17 .756	1	1	2	24	15	39	9	1	2	—	11	4	107	10 .874	10 .113
Tiverton	M.B.	14,030	1,899	254	18 .104	19 .190	1	3	1	48	28	53	15	2	—	—	12	5	164	11 .689	9 .351
*Tiverton	R.D.	20,840	3,045	306	14 .683	16 .592	4	7	3	51	50	102	39	1	1	—	21	10	278	13 .339	11 .205
Barnstaple	M.B.	16,320	2,703	307	18 .811	19 .752	3	7	1	48	40	112	31	5	5	—	16	11	269	16 .483	12 .527
Barnstaple	R.D.	27,560	4,519	426	15 .457	18 .857	7	9	—	69	74	167	29	9	2	—	28	12	390	14 .151	11 .745
South Molton	M.B.	2,990	562	28	9 .364	11 .518	—	—	1	11	6	27	7	2	—	—	10	1	65	21 .740	10 .000
*South Molton	R.D.	8,410	1,349	129	15 .339	18 .253	5	7	—	16	14	32	10	1	—	—	14	5	92	10 .939	9 .845
Ilfracombe	U.D.	8,230	1,853	140	17 .011	21 .774	—	—	1	30	30	55	13	2	1	—	6	5	143	17 .375	11 .641
Torrington	R.D.	7,300	1,187	111	15 .205	18 .094	—	—	—	20	9	46	8	—	2	—	9	6	100	13 .699	12 .603
Northam	U.D.	7,220	1,440	89	12 .327	15 .655	3	4	—	29	13	47	17	2	3	—	11	2	124	17 .174	12 .022
Bideford	M.B.	10,830	1,839	169	15 .605	17 .633	6	7	3	24	24	74	19	2	—	—	8	3	157	14 .497	10 .148
*Holsworthy	R.D.	8,640	1,085	129	14 .931	17 .219	1	2	—	16	21	38	9	2	—	—	9	2	97	11 .227	9 .247
Great Torrington	M.B.	2,880	558	36	12 .500	14 .875	—	1	—	17	9	28	7	2	—	—	4	2	69	23 .958	13 .416
Bideford	R.D.	5,070	788	84	16 .568	19 .218	1	1	—	8	5	22	8	—	—	—	9	1	53	10 .454	9 .827
Lynton	U.D.	1,680	323	21	12 .500	14 .25	—	—	—	12	1	6	1	—	—	—	1	—	21	12 .500	8 .750

Districts		Popla-tions (Estim'td) Home)	Estimated Population Aged 65 Years and Over	Births			Infant Deaths		Tuberculosis and Other Infactions Diseases	Cancer & Other Malignant Diseases	Vascular Lesions of Nervous System	Heart and Circulatory System	Respiratory (excluding Tuberculosis)	Stomach & Digestive System	Genito-Urinary	Maternal	All Others	Accident, Suicide, etc.	Total Deaths		
					Rates per 1,000 Population		Under 4 weeks	Under 1 year													
				No.	Crude Rate	Cor'd Rate	No.	No.	1-9	10-15	17	18-21	22-25	26-27	28-29	30	16, 31 32	33-36	No.	Crude Rate	Cor'd Rate
Okehampton	M.B.	3,810	747	60	15.748	17.795	1	1	—	15	12	26	12	—	—	—	5	3	73	19.160	11.680
Okehampton	R.D.	11,390	2,263	158	13.872	17.756	2	2	—	24	28	68	20	3	—	—	6	5	154	13.521	10.592
Salcombe	U.D.	2,420	534	33	13.636	18.136	1	1	—	5	1	16	5	—	1	—	3	—	31	12.810	8.070
Kingsbridge	U.D.	3,320	565	33	9.940	11.628	—	—	—	12	6	23	3	—	—	—	2	1	47	14.157	12.600
Kingsbridge	R.D.	11,810	2,124	158	13.378	16.321	2	2	2	30	24	62	25	1	1	—	13	1	159	13.463	10.770
Plympton St. Mary	R.D.	48,030	6,243	847	17.635	18.164	10	14	3	104	89	212	64	5	4	—	51	11	543	11.305	9.948
*Tavistock	R.D.	22,510	4,143	302	13.416	16.368	2	2	1	67	39	135	29	3	—	—	19	7	300	13.327	11.062
Totnes	R.D.	15,980	3,013	219	13.705	17.404	1	2	2	42	41	97	46	1	2	—	24	15	270	16.896	9.631
Totnes	M.B.	5,620	1,055	67	11.922	14.189	3	4	1	17	14	46	10	1	—	—	38	4	131	23.309	13.986
Buckfastleigh	U.D.	2,520	504	30	11.905	15.833	1	2	—	7	5	16	2	1	—	—	4	2	37	14.682	10.571
Ashburton	U.D.	2,850	552	65	22.807	26.228	—	—	—	8	8	14	5	1	—	—	4	5	45	15.789	10.427
Dawlish	U.D.	7,820	1,631	90	11.509	15.537	3	3	4	22	16	62	11	—	2	1	18	7	143	18.286	13.349
Teignmouth	U.D.	11,830	2,978	139	11.750	16.567	1	2	3	38	30	83	16	2	3	1	15	6	197	16.652	9.658
Newton Abbot	U.D.	18,630	3,479	307	16.479	18.291	1	2	2	37	52	150	25	2	—	—	47	8	323	17.337	10.575
Newton Abbot	R.D.	28,190	5,382	408	14.473	17.368	2	3	3	92	61	165	45	5	8	—	34	17	430	15.254	10.983
Torquay	M.B.	52,300	12,865	719	13.748	17.459	9	18	10	161	134	395	76	3	3	—	80	32	894	17.094	11.111
Dartmouth	M.B.	7,010	1,109	101	14.408	18.874	1	1	1	10	5	36	5	—	3	—	11	2	73	10.414	9.685
Brixham	U.D.	12,410	2,292	202	16.277	21.486	1	2	1	39	39	71	9	2	2	—	23	6	192	15.471	9.901
Paignton	U.D.	31,470	7,926	387	12.297	16.356	5	11	3	92	91	215	54	3	5	—	42	13	518	16.460	11.522
Administrative County		561,390	106,092	8179	14.569	17.628	94	145	54	1575	1311	3413	877	88	75	3	787	298	8481	15.107	10.575

* *NOTE:* Statistics of area whose boundaries have been altered are composite figuers combining the "before change" and "after change" position for the respective periods involved. The population shown is a constructed figure appropriate for use with the partial or mixed records of births and deaths in the current year.

PART II

DISTRICT MEDICAL OFFICERS OF HEALTH

DISTRICT MEDICAL OFFICERS OF HEALTH

District Councils		District Medical Officers of Health
Exmouth	U.D.	L. G. Anderson, M.D., D.P.H. ("mixed" appointment)
Budleigh Salterton	U.D.	
St. Thomas	R.D.	
Ottery St. Mary	U.D.	R. C. MacLeod, M.D., D.P.H., D.T.M.& H., ("mixed" appointment)
Sidmouth	U.D.	
Honiton	M.B.	
Seaton	U.D.	
Axminster	R.D.	
Honiton	R.D.	
Barnstaple	M.B.	E. Williams, M.R.C.S., L.R.C.P., D.P.H. ("mixed" appointment) — Stella C. Candler, M.B., Ch.B., M.R.C.S., L.C.R.P. Deputy Medical Officer of Health. Commenced 1.6.66
Barnstaple	R.D.	
South Molton	M.B.	
South Molton	R.D.	
Ilfracombe	U.D.	
Torrington	R.D.	
Northam	U.D.	
Bideford	M.B.	
Holsworthy	R.D.	
Great Torrington	M.B.	C. F. R. Briggs, M.B., B.S., M.R.C.S., L.R.C.P.
Bideford	R.D.	N. B. Betts, M.B., B.Chir., F.R.C.S., L.R.C.P.
Lynton	U.D.	M. P. Nightingale, M.R.C.S., L.R.C.P.
Crediton	U.D.	N. F. Sawers, M.B., Ch.B.
Crediton	R.D.	L. N. Jackson, B.A., D.M.
Tiverton	M.B.	G. Nicholson, M.D., D.P.H., F.R.C.S. (combined appointment)
Tiverton	R.D.	
Okehampton	M.B.	E. D. Allen-Price, M.D., D.P.H. (dec'd 7.2.66)
Okehampton	R.D.	Mary E. Budding, BSC., M.B., B.Ch., D.P.H. (w.e.f. 8.2.66)
Salcombe	U.D.	R. B. Walker, M.R.C.S., L.R.C.P., D.P.H. ("mixed appointment) (resigned 31.10.66) — Mary E. Budding, B.SC., M.B., B.Ch., D.P.H., Deputy Medical Officer of Health. Commenced 1.4.66
Kingsbridge	U.D.	
Kingsbridge	R.D.	
Plympton St. Mary	R.D.	
Tavistock	R.D.	
Totnes	M.B.	
Totnes	R.D.	
Buckfastleigh	U.D.	
Ashburton	U.D.	H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H. ("mixed appointment)
Dawlish	U.D.	
Teignmouth	U.D.	
Newton Abbot	U.D.	
Newton Abbot	R.D.	
Torquay	M.B.	D. K. MacTaggart, M.A., M.B., Ch.B., D.P.H. ("mixed" appointment)
Dartmouth	M.B.	J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H. ("mixed" appointment)
Brixham	U.D.	
Paignton	U.D.	

DISTRICT MEDICAL OFFICERS OF HEALTH

In the greater part of Devon the district medical officer of health holds a "mixed" appointment. The effect of this is that the medical officer spends a proportion of his time, varying from 85 per cent to 80 per cent, undertaking public health duties for one of more district councils. The remaining proportion of his time is spent in duties for the county council which are mainly connected with the school health and child welfare services. With the mixed type of appointment a most valuable link is forged between the district medical officer of health and the county health department.

In one area a "combined" appointment was established several years ago. In this type of appointment the district medical officer is responsible solely for the work of his district councils and officially takes no part in the work of the county council. It should however be added that the medical officer of health concerned takes considerable interest in the work of the health department and has been most helpful in arranging and attending meetings with general practitioners in his area when health centres and other county council services have been discussed.

The medical officer of health for five district councils is also a general practitioner practising in the area. Great Torrington and Lynton are two such areas. The latter now has a functioning health centre, whilst at the former plans for one are well advanced.

During the year two major changes took place. The first of these concerned the amalgamation of the greater parts of areas 4 and 5, as fore-shadowed in the 1965 report. This has to be looked upon as a temporary arrangement until the county's overall scheme has been approved by the Ministry of Health. Dr. E. Williams is the acting medical officer of health and Dr. S. Candler the acting deputy for the new area.

Following the resignation of Dr. McQuaid from area 10 and the death of Dr. Allen-Price (area 6), and bearing in mind that on the 1st April, 1967 there will probably be a loss to Plymouth of the most populous part of the Plympton R.D.C. (area 7), negotiations were commenced with the district councils concerned. It was finally agreed with these constituent councils that an amalgamation should take place of the whole of area 7 with Tavistock rural district from area 6, Totnes municipal borough and rural district and Buckfastleigh urban district from area 10. Dr. R. Walker became the acting medical officer of health of the amalgamated areas and Dr. M. Budding his deputy. This temporary arrangement commenced on the 1st April, 1966 and is again subject to the Ministry's confirmation.

Ashburton urban district joined area 8, and Okehampton municipal borough and rural district decided to form an area of their own, with Dr. M. Budding acting as medical officer of health. Later in the year Dr. Walker resigned to take up an appointment in Canada.

Tavistock urban and rural districts amalgamated on the 1st April, 1966.

PART III

EPIDEMIOLOGY

Notification of Infectious Disease

Vaccination and Immunisation

TUBERCULOSIS

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease

This table affords a comparison with the preceding five years:

	Number of corrected notifications					
	1961	1962	1963	1964	1965	1966
Measles	6,448	2,664	6,085	2,679	5,863	2,700
Whooping Cough ..	592	68	197	322	89	175
Diphtheria	1	—	—	1	—	—
Poliomyelitis ..	—	—	—	—	—	—
Scarlet Fever	121	99	152	142	145	140
Erysipelas	23	22	19	24	25	14
Pneumonia	198	127	178	121	81	129
Meningitis	2	1	6	8	4	3
Tuberculosis	158	156	117	110	131	122
Typhoid or paratyphoid	4	2	1	3	—	—
Dysentery	31	419	167	70	52	109
Food Poisoning ..	33	19	36	87	26	48
Ophthalmia Neonatorum	4	3	1	2	—	8
Puerperal Pyrexia ..	4	11	7	10	8	6

For the fifth year in succession, no cases of poliomyelitis were notified in Devon and this is considered to be mainly due to the successful vaccination campaign.

There was no notification of diphtheria this year.

There were more cases of dysentery this year, and this together with the 48 cases of food poisoning shows an obvious need for more personal hygiene education, particularly of those handling food.

Venereal Diseases

	New Cases Treated					
	1961	1962	1963	1964	1965	1966
Syphilis	7	6	4	18	14	15
Gonorrhoea	38	49	50	106	102	104
Other conditions ..	220	300	306	279	374	447

Venereal diseases are not notifiable and the figures shown above are only in respect of cases treated at the special centres. It is obvious that these figures are an unknown fraction of the total cases of venereal disease occurring in the area.

Vaccination and Immunisation

DIPHTHERIA, WHOOPING COUGH AND TETANUS (Combined Immunisation)

The use of combined prophylactics involves fewer injections and is thus more acceptable to parents and infants, and there is a greater probability of a course being completed. Three injections are recommended; the first after two months but before six months, and the second a month afterwards and the third a month after the second dose. A booster dose is offered at approximately eighteen months. Supplies of the vaccine can be obtained by doctors from the county health department together with the necessary record cards. Supplies of separate diphtheria, whooping cough or tetanus prophylactics are also available should these be required.

Diphtheria Immunisation (including combined immunisation)

The numbers of children who received immunisation since 1948 are shown in the following table. In 1965 the Ministry of Health revised the age groupings, hence the changed setting of the table as from that year.

Year	No. of children who completed a full course of immunisation			No. of children who were given a reinforcing injection
	Under 5	5-14	Total	
1948	2,379	209	2,388	1,030
1949	5,787	1,015	6,802	9,133
1950	4,460	572	5,032	5,288
1951	5,206	582	5,788	7,345
1952	4,838	574	5,412	8,798
1953	4,554	833	5,387	9,243
1954	4,865	959	5,824	8,329
1955	4,535	844	5,379	8,602
1956	4,914	690	5,604	7,564
1957	4,590	694	5,284	6,144
1958	4,058	473	4,531	4,048
1959	6,490	646	7,136	3,839
1960	5,799	561	6,360	4,247
1961	5,782	824	6,606	3,708
1962	6,394	1,107	7,501	3,866
1963	6,847	946	7,793	4,197
1964	6,857	703	7,560	6,883

	Under 1	1–	2–	3–	4–7	Others under age 16	Totals	Booster
1965	2810	3085	522	206	509	310	7442	7,500
1966	2975	3159	390	152	498	599	7773	7,500

Whooping Cough (including combined immunisation)

The number of children protected against whooping cough during 1966 is as follows:

	Year of Birth					Others under age 16	Total	Booster
	1966	1965	1964	1963	1959-62			
A.C.M.O's.	1358	194	51	20	61	266	1950	1239
G.P's. ..	1612	2954	327	120	162	63	5238	2344
Total ..	2970	3148	378	140	223	329	7188	3583

Tetanus

Older children who did not have the opportunity to receive tetanus immunisation in infancy, have in some areas been offered a full course of 3 injections. This involves a great deal of extra work for the medical officers concerned, but is very worth while.

Tetanus (including combined immunisation)

	Year of Birth					Other under age 16	Total	Booster
	1966	1965	1964	1963	1959-62			
A.C.M.O's.	1361	195	53	23	306	2141	4079	5658
G.P's. ..	1616	2984	347	134	207	949	6237	3935
Total ..	2977	3179	400	157	513	3090	10316	9593

Poliomyelitis

Vaccination against poliomyelitis is now offered to all persons who have not at the time of their application for vaccination reached the age of forty, and also to special groups of personnel and their families who may come into contact with poliomyelitis cases. Oral vaccine is used but salk vaccine can be made available if required. Persons going to visit or reside in a country outside Europe other than Canada or the United States of America may also receive vaccination against polio.

In the autumn of 1965 the Ministry of Health gave permission for routine poliomyelitis vaccine to be administered at the same time as the "triple" immunisation and most medical officers have taken advantage of this. It reduces the number of the visits of the child to the clinic for these procedures by 3, and mothers much appreciate this. However, it means that the polio vaccination is commenced at an earlier age than before and the baby's response to the vaccination may be slightly less effective. To compensate for this possible deficiency, a booster poliomyelitis vaccination dose is therefore offered at eighteen months, as well as on school entry, in order to ensure a satisfactory response.

Salk Poliomyelitis Vaccinations

	Year of Birth					Others under age 16	Total	Booster
	1966	1965	1964	1963	1959-62			
A.C.M.O's.	7	15	9	1	3	4	39	141
G.P's ..	57	246	82	21	53	177	636	171
Total ..	64	261	91	22	56	181	675	312

Sabin (Oral)

	Year of Birth					Others under age 16	Total	Booster
	1966	1965	1964	1963	1959-62			
A.C.M.O's.	1377	291	63	43	302	350	2426	4164
G.P's. ..	972	2949	543	179	315	568	5526	2632
Total ..	2349	3240	606	222	617	918	7952	6896

Smallpox

Smallpox vaccination should be carried out preferably sometime during the second year of life. Supplies of lymph vaccine can be obtained from the County Health Department. Telephone (77977) Extention 514. Record cards also obtainable from the county health department, are completed by the doctors and returned to the county medical officer in respect of each vaccination carried out.

International certificates of vaccination (issued by the Ministry of Health), required before visitors are admitted to certain overseas countries, are submitted to the local district medical officer of health for the purpose of authenticating the doctor's signature.

The following table shows the number of vaccinations and re-vaccinations performed during the last five years.

	VACCINATIONS						RE-VACCINATIONS					
Year	Under 1	1	2-4	5-14	15 or over	Total	Under 1	1	2-4	5-14	15 or over	Total
1962	1839	3277	2339	8400	15404	31259	—	99	689	9380	32093	42261
1963	526	1430	348	389	791	3484	16	28	106	557	2180	2887
1964	463	2232	1012	106	363	4176	6	36	99	345	1672	2158
Year	Under 1	1	2-4	5 15	Total		Under 1	1	2-4	5-15	Total	
1965	42	2013	1761	223	4039		15	10	156	528	709	
1966	435	2319	1989	322	5065		8	47	196	1037	1288	

Measles

Vaccination is not at present offered to children by the local authority.

Record Cards

Special personal record cards are issued to mothers attending welfare centres, and supplies are available to general practitioners on request. The importance of having these cards completed after each injection is stressed to the parents, who are also advised to produce it whenever a child attends a doctor or hospital following an accident. If the doctor has evidence of a satisfactory primary course of tetanus immunisation he will be able, under such circumstances, to give a booster dose of tetanus toxoid rather than A.T.S., and thus avoid the danger of serum sensitization.

Prophylactics can be obtained as follows:

Vaccine	*Centre*
Triple prophylactic Diph./Tetanus prophylactic T.A.F. Whooping cough Tetanus Oral polio vaccine Salk Polio Vaccine (if required)	County Health Department, County Hall, Topsham Road, Exeter (Tel. 77977, ext. 514). or *in small quantities* direct from Barnstaple—The Clinic, 19b, Alexandra Road (Tel. 5137—Dr. Williams. Bideford — The Clinic, Coronation Road (Tel. 3163) — Dr. Candler. Brixham—The Clinic, Greenswood Road (Tel. 3374) — Dr. J. MacTaggart. Buckfastleigh Health Centre, 7 Bossell Road (Tel. 2171). Budleigh Salterton Health Centre, 1 The Lawn (Tel. 2213). Crediton—The Clinic, "Newcombes" (Tel. 2649)—Dr. Tait. Dartmouth—New Centre, Mayor's Avenue (Tel. 2845)—Dr. J. MacTaggart. Exmouth—The Clinic, 89 Withycombe Road (Tel. 2610) — Dr. Anderson. Honiton—Municipal Offices, New Street (Tel. 391) — Dr. MacLeod. Ilfracombe—The Health Centre, Malborough Road (Tel. 3521)—Dr. Dunn. Ipplepen Health Centre, Biltor Road (Tel. 621). Lynton Health Centre, Burville Street (Tel. 3226). Kingsbridge—The Clinic, "Tresillian", Fore Strect (Tel. 2606) Newton Abbot—The Clinic, 21 Courtenay Park (Tel. 2445)—Dr. Davies. Okehampton Health Centre, Memorial Hospital Grounds (Tel. 731). Ottery St. Mary Health Centre, 74 Sandhill Street (T l. 2288). Paignton—The Clinic, 14 Midvale Road (Tel. 59131)—Dr. Wildman. Tavistock—The Clinic, Crowndale Road (Tel. 2617) — Dr. Budding. Tiverton—The Clinic, Rock Close, St. Andrew's Street (Tel. 3341)—Dr. Tait. Torquay—The Clinic, 15 Castle Road (Tel. 27963)—Dr. Solomon. Torquay—Health Dept., St. Marychurch Town Hall (Tel. 38204) —Dr. D. MacTaggart.
Smallpox Vaccine	County Health Dept., County Hall, Exeter (Tel. 77977). (Ext. 514)

B.C.G. (Anti-Tuberculosis)

Vaccination is undertaken by the chest physicians for infants and young children exposed to infection from a known case of tuberculosis. B.C.G. vaccination is offered to school children of over eleven years of age, and also young adults attending colleges, technical schools, etc. Parents have the opportunity of giving their consent to this procedure and the vaccination is carried out by specially trained medical officers.

	School Children	Students Attending Further Education Establishments
No. of Children on Roll	5,162	—
No. of children for whom parental consent received	4,335	1
No. tuberculin tested (Heaf tested 2 mm. puncture)	4,315	1
No. positive	675	—
No. negative	3,553	1
No. given freeze-dried B.C.G. vaccine	3,592	1

It will be noted that the number of children receiving B.C.G. vaccination is higher than the number of children found negative on Heaf testing. This is because some medical officers routinely vaccinated Grade I Heaf positive children. It has now been decided, in consultation with the chest physicians, that all Grade I Heaf positive children should in future be vaccinated.

TUBERCULOSIS

This year 122 cases were notified, a slight fall over last year.

Age	Pulmonary		Non-Pulmonary		All forms T.B.		Totals				
	M	F	M	F	M	F	1966	1965	1964	1963	1962
Under 5	3	1	0	0	3	1	4	4	2	4	2
5—14	4	2	0	0	4	2	6	11	9	7	9
15—24	7	5	3	2	10	7	17	19	14	14	16
25—34	5	6	2	0	7	6	13	19	14	14	30
35—44	5	5	2	2	7	7	14	19	20	21	24
45—54	13	3	2	8	15	11	26	22	15	26	25
55—64	13	4	2	1	15	8	20	17	12	18	24
65+	13	4	1	4	14	8	22	19	23	13	25
Unknown	—	—	—	—	—	—	—	1	1	—	1
Totals	63	30	12	17	75	47	122	131	110	117	156
	93		29*		122						

*Includes 11 cases of T.B. glands, 7 abdominal, 3 genito-urinary system, 3 bones and joints, 1 meningeal, 4 others.

Detection

How Picked Up	Pulmonary	Non-Pulmonary	Total
G.P. to Chest Clinic	43	8	51
G.P. to Mass X-Ray	3	—	3
Contacts of known cases ..	9	—	9
Hospitals	19	19	38
Public Sessions Mass X-Ray ..	15	—	15
Tests (Heaf)	2	—	2
No information available ..	2	2	4
Totals	93	29	122

Contacts

Contacts examined		No. of cases of T.B. found
Household Adults	176	6
..Children	90	5
Total household	266	11
Neighbours, friends or relatives not living in household	116	—
Contacts at work, in school or elsewhere	251	—

Every case of tuberculosis must have a source and every contact runs a higher risk than the general population of contracting tuberculosis.

Treatment—Chest Clinics. The work of the four chest clinics is summarized in the table below:

	Torquay	Barnstaple	Exeter	Plymouth	Total
Patients on Register 1.1.66 ..	699	469	1,349	366	2,883
New Notifications:					
(a) respiratory	31	16	40	16	103
/b) non-respiratory	3	9	11	4	27
Deaths	20	3	5	6	34
Patients on Register 31.12.66	633	349	738	315	2,035
First examination of suspects ..	911	225	1,077	659	2,872
Cases of T.B. found	41	10	25	18	94
Contacts examined	225	173	194	48	640
Cases of T.B. found in contacts	0	1	8	2	11
Contacts vaccinated with B.C.G.	113	89	113	41	356

Dr. Wyndham Lloyd (Torquay) states that the downward trend in the new cases of tuberculosis, after having been halted in the last few years, has now been resumed. There were 34 new notifications, as compared with 50 in 1965, 39 in 1964 and 46 in 1963.

The number of deaths of patients on the tuberculosis register was 20, compared with 17 last year; but again it should be pointed out that nearly all of the deaths were among the very old, many of them having had tuberculosis for years. Furthermore only one quarter of these deaths were actually from tuberculosis, the others being from diseases incidental to old age, notably cardiovascular troubles. The average age at death has once more risen, to over 71 years as opposed to 63 in 1964 and 66 in 1965. The average interval between notification and death has also risen from nine years in 1965 to twelve years in 1966. These figures show the life-prolonging effects of modern treatment.

The total number of tuberculous patients on the register at the close of the year was 633, the lowest yet recorded.

No case of tuberculosis among immigrants has been found in this area.

Dr. Adkins (East & Central Devon) reports that there is very little change in the overall pattern of new notifications in the last few years, but it is of some interest that the proportion of cases first discovered by "contact" examination is the highest yet recorded. From these two observations it is pertinent to comment that the tuberculosis problem, although greatly reduced in the last decade, is likely to remain with us for many years yet, and that it remains an infectious illness and therefore control will only be gained finally if the direction remains with the public health authorities. There is a feeling in some quarters that tuberculosis can now be relegated to the general hospitals as just another chest disease, and he feels this is a retrograde attitude.

The other point for comment is that the size of the register has been greatly reduced as he indicated would be the case in his comments last year. The entire register has been overhauled and all cases quiescent and otherwise satisfactory for over five years are taken off as "cured", although many of them will, of course, continue to attend from time to time. This overhaul is not yet quite complete and a further reduction will take place during the present year.

It appears there is little uniformity throughout the country about the length of time cases are kept routinely on the register and many areas keep all cases on at least ten years. Now that the satisfactory end-results of modern chemotheraphy have become apparent, it would appear more realistic to reduce the period for retention on the register to two years after completion of satisfactory treatment, although many will continue to attend the clinic for routine supervision as previously.

Routine Heaf testing of all primary school children in 1966 revealed only 2 cases of tuberculosis, one of these a school child, the other the father of a school child.

At a meeting with the chest physicians at the end of the year it was agreed that the scheme could be modified and that only school entrants would be Heaf tested in future.

The figures for the school year September 1965 to August 1966 are as follows:—

	Found Positive on first testing	Converted to Positive on subsequent test	Total
Found Positive	109	212	321
Positive Children X-rayed	35	85	120
Contacts X-rayed (Adults)	75	94	169
(Children)	8	8	16
Cases picked up: Positive Children	—	1	1
Adult Contacts	1	—	1
Child Contacts	—	—	—

No. of schools tested—246. No. of children tested (all ages)—26,017.

Dr. Midgley reports as follows on children of school age resident in the county of Devon, treated in Hawkmoor Chest Hospotal during the year ended 31st December, 1966;—

"There were no children in the hospital on 1.1.66. Three tuberculous and eighteen non-tuberculous children were admitted during the year. One tuberculous child remained in at 31.12.66 but is now past school-leaving age."

These children were grouped clinically as follows

Tuberculous		*Non-Tuberculous*	
R.A.1	2	Observation	4
R.B.1	1	Bronchitis	2
		Bronchiectasis	7
		Empyema	2
		Hiatus Hernia	1
		Neuroblastoma	1
		Patent Ductur Arteriosus	1

TUBERCULOUS CHILDREN

In one of these children there was a history of contact with an open case of tuberculosis.

All the children in this group have responded well to sanatorium regime and chemotherapy.

NON-TUBERCULOUS CHILDREN

Five children had surgical treatment, the remainder responded well ot medical measures.

FITNESS FOR SCHOOL ON DISCHARGE

Of the children discharged, thirteen were considered fit for school, one was unfit, and the remainder required a further period of convalescence.

AVERAGE LENGTH OF STAY

Tuberculous	Eight weeks
Non-Tuberculous	Three weeks

No child of school age died in hospital during the year.

PART IV

LOCAL HEALTH SERVICES

Care of Mothers and Young Children

Midwifery

Home Nursing

Health Visiting

Home Help Service

Health Education

Ambulance

Adult Health

MATERNAL HEALTH AND NURSING

Maternity Services

There have been many changes in the maternity services since the introduction of the National Health Service Act, in 1948, at which time the Devon County Council, took over the administration and staff of the domiciliary service from the Devonshire Nursing Association. The County Council continued the progressive outlook of the D.N.A. and soon all midwives were trained in the giving of analgesia and the attending of refresher courses to keep them up to date in their practice. All were encouraged to become car drivers and telephones were supplied to improve working facilities. Today the idea of a domiciliary midwife without a car or 'phone is unthinkable.

In the county 8,140 live births were notified during the year (as adjusted for transfers in and out).

Domiciliary	1,974
Institutional	6,166
	8,140

1966 again had a lower total of births for the second year in succession. There is a drop both in the crude and the corrected birth rates, but the greater difference in the crude rate for 1965 and 1966 emphasises the increasing proportion of older persons in the Devon population. For the fifth year in succession early discharge from hospital is more common and now is a feature of more than one-third of all hospital deliveries. The domiciliary midwives are undertaking willingly this extra work, but some are finding themselves very pressed. There is occasional anxiety over the hospital case who insists on discharging herself against advice to an unsuitable and unprepared home. So far, however, no harm to mother or child has been observed.

Ante-natal Clinics

In 1948 there were nine county clinics staffed by medical officers and midwives. As general practitioners rapidly took an increasing interest in the care of the expectant mother, the medical sessions ceased and are now entirely superseded by health education and relaxation classes conducted by the midwives and health visitors.

During the year the classes at Pinhoe and Topsham were transferred to Exeter and new classes were started at Broadclyst, Buckfastleigh, Harberton, Lynton, Marldon and Salcombe. There are now 39 clinics in which the district midwives and health visitors together give courses on health education, exercise and relaxation. About 40 per cent of the expectant mothers in the county attend these classes, most of these expecting their first baby. 3,212 mothers made a total of 12,539 attendances.

It is felt that the mothers at present attending are enthusiastic and appreciate the service, but there is obviously room for improvement in the attendance figures, particularly with those expecting their second and subsequent babies. In the busier centres staff are having difficulty in finding time to duplicate the sessions to meet the demand. Health education sessions are more time-consuming than physical examinations as there is a considerable amount of preparation of talks and visual aids before each session.

Most expectant mothers, however, feel that individual advice does not meet all their needs and more and more they are asking for the opening of new centres. The demand is for group teaching and discussion in which husbands may also take part in at least some sessions.

Dental Care of Expectant and Nursing Mothers and their Children

Once again there was an increase of the previous year from 844 to 915 in the number of infants inspected but the number needing treatment went down from 448 to 409. This is most gratifying as it indicates that more mothers are realising the value of presenting their children for inspection before the necessity for treatment becomes likely or apparent. Miss Billings in her report says "I particularly enjoy this age group for I am sure that if these children are brought to the surgery from an early age, when a little fun and games and perhaps the minimum of treatment is all that is involved, much of the fear and neglect so often seen would be eliminated and the patient would attend regularly in the future." It is most unfortunate that as so often happens a child's first experience of dentistry involves an anaesthetic or unpleasant instrumentation after one or more sleepless nights. Mr. Hunt, on the same subject, says "On the brighter side must be mentioned the slowly but steadily increasing number of parents who are willing, and indeed eager, to bring children for dental inspection and advice quite early in pre-school years. Some of them are, in fact, a little over eager—there have been several cases over the last year of parents bringing children in at the tender age of about eighteen months, for dental inspection". But even this is not too early. The sooner the child gets accustomed to the sight of dental equipment, the dentist's white coat, the smell of the surgery and the feel of a mirror in the mouth, the easier it is when the time comes for treatment. With the reduction in the number of children treated there was a corresponding fall in the total amount of treatment given. Another pleasing feature shown by the figures is the fact that 72 children had an additional course of treatment during the year and this would indicate that at least twice this number attended for a second inspection. There was a further fall in the number of mothers inspected and treated but an increase in the amount of treatment provided under all headings.

Family Planning

The highlight of the year was the receipt of Circular 5/66 from the Ministry of Health. For the first time this encourages local authorities to give information on this subject through, in the main, the health visiting and nursing staffs. It recommends that those women needing advice for medical or obstetrical reasons should receive this and any supplies required without charge. There is, furthermore, the suggestion that at a later date all married women who so wish should be able to receive free advice.

This circular obviously envisages a great expansion in the facilities for giving contraceptive advice.

In Devon for many years the county council has given a grant to the Family Planning Association and its associate bodies for this work. Increasingly, rent-free county council premises are being made available to the F.P.A. Several clinics have increased the number of clinics held and one new centre opened at Plymstock at the end of the year. Appreciation should again be recorded for the ready way in which women in difficult financial circumstances are seen and advised free of charge and "red tape". At all times there has been a ready understanding between the F.P.A. and the local authority.

During the year the F.P.A. carried out major changes in its methods of administration. There is now a Devon and Cornwall Branch with its own committee and organising secretary. The County Medical Officer is a member of the branch committee. These changes included the re-organisation of clinic records and consequently there are no accurate figures available of the number of Devon women who availed themselves of the facilities.

Cervical Cytology

The Minister of Health has approved a county council scheme for Devon. Under this scheme smears have been taken at convenient major county clinics and the cytological investigations carried out at the laboratories of the Regional Hospital Board. The clinics are staffed by women doctors and nurses. Appointments are only made after the general approval of the family doctor has been obtained for his patients to be seen.

During the year the service was extended to cover the whole county wherever there were suitable county council premises and available hospital technicians. There was a marked improvement in the number of technicians available and by the end of the year waiting lists were considerably reduced. During the year 4,652 women attended the clinics with 10 positive results.

The number of positives is less than to be expected from an average sample of the population. In Devon, in common with many other authorities undertaking this service, it is found difficult to attract women from the semi and unskilled sections of the population to the clinics. This is unfortunate as this is the very group in which experience shows there is the highest incidence of this type of cancer. Some authorities have indeed started a domiciliary service in order to reach this group of the population. Plans are being made to undertake a special survey in one medium sized town in Devon in the coming year. In close liaison with the family doctors an attempt is to be made to examine as nearly as possible 100 per cent of all eligible women. In this particular survey attention will be directed to the presence of other untreated gynaecological conditions, breast cancer and unsuspected diabetes.

The seven women doctors doing the smear examination all comment on the considerable proportion of women who are in need of treatment for other conditions or who themselves seek advice on sexual, family planning or matrimonial problems. Those requiring other treatment have been referred to their family doctors. It is important to record that in some instances established cancer of the cervix and the breast have been discovered when the patients were completely symptom-free.

Care of Unmarried Mothers and their Children

The 629 illegitimate births show a continuing, although slight, rise.

The social agencies are still finding their work increases, particularly in regard to girls who come to Devon late in pregnancy, so as to keep their situation a secret from relatives and friends.

During the year 15 girls conceived under the age of fifteen, 25 under sixteen and 20 under seventeen years.

The social workers are directly employed by the Exeter Diocesan Council for Family and Social Welfare. The County Council makes an annual grant towards the cost of the work carried out by its workers.

During the year the council was concerned with 500 cases. 181 of these were referred by the health department. The number of cases admitted to mother and baby homes rose to 76. Thirty-six of these were admitted to St. Nicholas House, Exeter, where five places are reserved for Devon girls. In addition the county council accepted partial financial responsibility in respect of the maintenance of 40 girls in homes as follows:

St. Olave's House, Exeter	13
Southview, Plymouth	20
Mayflower Home, Plymouth	4
Homes outside Devon	3
	40

Births

Registered live births numbered 8,179 compared with 8,459 in the previous year and an annual average of 8,046 in the quinquennium 1961–1965. The corresponding crude birth rates were 14.6, 15.0 and 14.7 respectively. For the second year in succession the total number of births has fallen after a steady annual rise since 1956.

The live birth rates for the past ten years, adjusted by the factors applicable for the aggregates of boroughs and urban districts, rural districts, the administrative county, also the national rate, are given below:

	Boroughs and Urban Districts	Rural Districts	Administrative County	England & Wales
1957	14.0	16.6	15.2	16.1
1958	13.7	16.7	15.1	16.4
1959	14.2	16.8	15.4	16.5
1960	14.2	16.9	15.5	17.1
1961	14.5	17.0	15.1	17.4
1962	14.8	17.8	16.1	18.0
1963	17.4	18.3	17.9	18.2
1964	18.3	18.4	18.3	18.4
1965	17.7	18.4	18.2	18.0
1966	17.6	17.7	17.6	17.7

Infant Deaths

Total infant deaths are somewhat raised at 145 (126) but as usual the great majority of these occurred in the first four weeks of life and are referred to in those sections. Only 51 occurred after the first month of life and the main causes of loss of life were 12 from respiratory infections, 7 associated with inhalation of vomit, 5 from congenital heart defects, 3 each from congenital brain abnormalities and acute enteritis, and 2 each from asphyxia, multiple deformities, liver failure and amyotoma congenita. 2 children died as a result of violence. Other miscellaneous causes included one case each of gas poisoning, leukaemia, eosinophilic granuloma and acute gastric haemorrhage.

Infant Welfare Services

The vital statistics for 1966, set out in the form requested by the Minister of Health, are:

	Administrative County	England and Wales
Live Births:		
Number	8,179	
Corrected Rate per thousand population	17.6	17.7
Illegitimate live births (629) per cent of total live births	7.69	
Stillbirths		
Number	100	
Rate per 1,000 total live and stillbirths	12.08	15.4
Total live and stillbirths	8,279	
Infant deaths (deaths under one year)	145	
Infant Mortality Rates:		
Total infant deaths per 1,000 live births	17.73	19.0
Legitimate infant deaths (135) per 1,000 legitimate live births	17.88	
Illegitimate infant deaths (10) per 1,000 illegitimate live births	15.90	
Neo-natal Mortality Rate (deaths under four weeks (94) per 1,000 total live births)	11.49	12.9
Early Neo-natal Mortality Rate (deaths under one week (74) per 1,000 live births)	9.04	11.1
Peri-natal Mortality Rate (stillbirths and deaths under one week combined (174) per 1,000 total live and stillbirths)	21.02	26.3
Maternal Mortality (including abortion):		
Number of deaths	3	
Rate per 1,000 total live and stillbirths	0.36	

Stillbirths

These only numbered 102 compared with 139 in the previous year. This shows the importance of considering infant deaths and stillbirths together.

Domiciliary	10 including	4 premature stillbirths
Institutional	92 including	51 premature stillbirths
	102	55

A stillbirth certificate is issued by the doctor in attendance in each case, but a considerable proportion are recorded as cause unknown. Without a post-mortem examination accuracy is often impossible.

The following tables shows comparative stillbirth rates for the county and England and Wales over the years:

	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966
Devon	22.9	22.7	21.6	21.3	17.9	19.0	16.9	15.0	16.9	17.3	15.9	12.1
England and Wales	23.2	22.9	22.5	21.6	21.0	19.8	19.1	18.1	17.2	16.4	15.7	15.4

Neo-natal deaths

Neo-natal deaths were 94 compared with 77 in 1965. Of the number who died 53 were premature, the greater proportion being of a very low birth weight.

The following table shows comparative figures for the county and England and Wales from 1959:

	1959	1960	1961	1962	1963	1964	1965	1966
Devon	13.8	14.3	11.0	11.6	13.6	10.8	9.1	11.5
England and Wales	15.8	15.6	15.5	15.1	14.2	13.8	13.0	12.9

Early Neo-natal (1st week) deaths

These numbered 74, of whom no less than 44 were premature.

The following table shows comparative rates for the county and England and Wales from 1959:

	1959	1960	1961	1962	1963	1964	1965	1966
Devon	12.8	13.2	9.6	9.5	11.9	9.3	7.5	9.0
England and Wales	13.8	13.4	13.4	13.0	12.3	12.1	11.3	11.1

Perinatal Mortality

The term perinatal mortality describes the combination of stillbirths and deaths in the first week of life which provides an indication of the loss of infant life due to conditions associated with pregnancy and events during labour and delivery.

The following table shows comparative rates for the county and England and Wales from 1959:

	1959	1960	1961	1962	1963	1964	1965	1966
Devon	30.5	32.0	26.3	24.4	28.5	26.5	23.3	21.0
England and Wales	34.2	32.9	32.2	30.8	29.3	28.2	26.9	26.3

Premature Births

Premature live births totalled 474 compared with 521 for the preceding year. Four hundred and twenty-one of these survived the first twenty-eight days of life.

The following table shows the birth weight, place of birth and number of premature babies surviving in each group at the end of twenty-eight days:

Weight at birth	Premature live births—Total notified 474												Premature Stillbirths	
	Born in hospital				Born at home or in a nursing home									
					Nursed, entirely at home or in a nursing home				Transferred to hospital on or before 28th day					
		Died				Died				Died			Born	
	Total births	within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 days	Total births	within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 dyas	Total births	within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 days	in hospital	at home or in a nursing home
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1. 2 lb. 3 oz. or less	21	10	6	1	2	2	—	—	1	—	—	—	13	—
2. Over 2 lb. 3 oz. up to and including 3 lb. 4 oz.	30	5	3	5	—	—	—	—	6	—	1	—	15	2
3. Over 3 lb. 4 oz. up to and including 4 lb. 6 oz.	77	4	3	1	2	—	—	—	1	—	—	—	13	—
4. Over 4 lb. 6 oz. up to and including 4 lb. 15 oz.	87	2	3	—	6	—	—	—	—	—	—	—	3	—
5. Over 4 lb. 15 oz. up to and including 5 lb. 8 oz.	205	3	2	2	36	—	—	—	—	—	—	—	7	2
6. Total	420	24	17	9	46	2	—	—	8	—	1	—	51	4

Child Welfare Centres

There are now seventy-five child welfare centres operating in the county, three having been transferred to Exeter and one closed because of small attendances. Two new centres have been opened during the year.

No. purpose built	13
No. adapted and in full time use	12
No. used on sessional basis	50

Mothers continue to make full use of the facilities available and 14,985 children made a total of 88,156 visits. Particular encouragement is given to the mothers of abnormal and handicapped children to make use of the clinic services regularly so as to receive all possible supervision and suitable counselling as to ensure the best possible development of the child concerned.

The following are synopses of the views expressed by some of the medical officers of the child welfare centres:

"At the beginning of September routine 'development' examinations were started officially at the Honiton centre, and the mothers did appreciate these regular checks, and are beginning to bring their toddlers regularly for birthday examinations."

"In Devon we are fortunate that the school medical officer is also the child welfare medical officer and that the health visitor is also the school nurse. This ensures continuity of supervision from the day the midwife relinquishes care until school-leaving age. Continuity of supervision could profitably be vested in the one medical officer—for child welfare, school health, early years of employment and in colleges of further education".

"At the hearing assessment clinic the number of pre-school children referred continues to grow and was nearly one quarter of all those referred. These invariably take much more time and patience and many more sessions to test. The close team-work of the audiometrician and hearing assessment medical officer had evolved a routine which worked very well and gave remarkably accurate results."

Phenylketonuria

Health visitors have been testing babies as a routine since 1st September, 1959. All mothers are advised of the reason for this test and almost all decide to have it performed for their own children. There has been one positive case during the year which has been referred to the family doctor and consultant for treatment.

Congenital Dislocation of the Hip (Ortolani test)

In addition to many hospital staff the district midwives and health visitors have all been advised of the method of testing hips of the new-born infant. During the year six cases were detected and the children spared the prolonged treatment necessary when diagnosis is delayed.

Cases are still occasionally found when children have attained walking age. These children have all passed the Ortolani test soon after birth and this illustrates both the difficulties and disappointments which can occur in seeking to prevent the development of disabilities.

"At Risk" Register

This continues to be kept in accordance with the returns required by the Ministry of Health. No less than 2,960 out of the 8,179 births were placed on

the register. Similar figures are being found in other authorities, but children are still found who develop handicaps and had not been on the "At Risk" register. Some of these had, in fact, histories previously undisclosed which showed clearly that they should have been on the register. This stresses the need to carry out a critical survey of all children in their early years.

Distribution of Welfare Foods

Issues of National Dried Milk, cod liver oil and vitamin tablets continue to fall but it is interesting to note that there is a marked increase in issues of orange juice during the year. The following table shows comparable distribution figures for 1965 and 1966:

	National Dried Milk (Tins		Cod Liver Oil (bottles)		Vitamin Tablets (packets)		Orange Juice (bottles)	
Period	1965	1966	1965	1966	1965	1966	1965	1966
January—March	16828	12731	1660	1666	2086	1613	18733	21095
April—June	15546	12172	1336	1163	1756	1390	21896	23841
July—September	15380	13709	1329	1318	1697	1455	22843	25871
October—December	14728	12479	1407	1585	1720	1538	21155	22818
Totals	62482	51091	5732	5732	7259	5996	84627	93625

Welfare Foods are issued from 62 child welfare centres, 6 W.V.S. centres and 144 shops and private houses. I should again like to express appreciation to the many voluntary workers who undertake the actual work of distribution at these 212 distribution centres and to officials of district councils and other departments of the county council who act as area depot officers.

Registration of Nursing Homes

During the year one new nursing home was registered. Two proprietors returned the certificate of registration on retirement or change of usage.

At the end of the year there were 22 registered nursing homes providing 23 maternity beds and 311 medical, convalescent and chronic beds.

Nurses' Act, 1919–1945

Two applications for renewal of licences to carry on agencies for the supply of nurses under these Acts were received and approved during the year.

MIDWIFERY AND HOME NURSING

Staffing

There is a total establishment of 188 for home-nursing and midwifery. There is a superintendent nursing officer, a deputy and three assistant superintendents.

The work is mainly combined nursing and midwifery, but in some urban areas the work is separated and there are twenty-three full-time midwives and thirty-two full-time general nurses in addition to 124 undertaking combined work. Nine part-time nurses (equivalent of five full-time) are employed as home nurses. There were fourteen vacancies at the end of 1966.

Eleven nurses retired during the year.

Two rural areas in North Devon which became vacant on retirement of the two nurses were surveyed regarding population and work, and it was decided that West Down could be well served by a nurse appointed to be resident in Ilfracombe.

The same applied to Bratton Fleming, where it was known that the nurse was under employed. When she retired her successor was based at Barnstaple. It has been very difficult to get nurses to accept posts in very rural districts, but by re-grouping the districts it proved more attractive in recruiting staff. We have not found that the patients have had less satisfactory service.

Group System

For convenience of administration the county is divided into groups, each with a county staff sister, who is responsible for bulk ordering of stores through the health department and the distribution of stores to the staff in her group. She is also responsible for arranging relief for holidays and sickness.

Dissemination of Information

County staff sisters attend meetings called by the superintendent nursing officer at least four times a year, when all changes and problems are fully discussed. These meetings are usually attended by one, or more senior medical officers, and occasionally by the county medical officer.

Notes are taken at the meetings and a copy sent to each member of staff. The county staff sisters call meetings of nurses in their groups as soon as convenient after the meeting at headquarters, when full details of all that was discussed at the meeting are given. The superintendent nursing officer or an assistant superintendent nursing officer, attend the group meetings and occasionally a medical officer.

Communications

During the year arrangements have been made for the improvement of communications between district nurses and general practitioners. Transfer of telephone calls are now made in the Barnstaple, Tiverton, Newton Abbot, Paignton, Okehampton, Tavistock, Crediton and Exmouth areas.

At Paignton, Tavistock and Barnstaple the clinic clerks take messages from the doctors during office hours, and at Paignton there is a system by which a nurse attends the clinic at Midvale Road to receive telephone calls from doctors after evening surgery each day, and it is intended to install a recordaphone as at Torquay during 1967.

Application for the Domiciliary Services

Home nurses and midwives are listed in the telephone directory under the entry for Devon County Council health department, according to the district in which they practice. All medical practitioners and hospital almoners also have lists of the nursing and midwifery staff in their areas.

In the areas of Barnstaple, Tiverton and Newton Abbot, telephone calls are transferred when a nurse is off duty, and it is hoped to extend this service during the year, where telephone exchange facilities permit this arrangement.

MIDWIFERY

Miss Heather is the non-medical supervisor of midwives and is responsible for the code of practice by all midwives in the county including those in hospitals where there is no resident medical officer. She is assisted in these statutory duties by her deputy and three assistants, who act as assistant supervisors of midwives.

The work of the midwives is summarised in the following table:

Domiciliary deliveries attended	1,966
No. of mothers discharged from hospital after 48 hours	902
Nursing care of mothers discharged from hospital before tenth day	2,619
Attendances at G.P. ante-natal clinics	3,297
Attendances at county council ante-natal clinics	1,981
No. of cases in which gas and air or gas and oxygen was administered	1,416
No. of cases in which trilene was administered	167
No. of cases in which pethidine was administered	1,129
Total number of midwifery and ante-natal visits to home deliveries	55,852
Total number of ante-natal visits to hospital booked patients	16,998

The recordaphone is use at Torquay is of assistance to midwives held up on cases, as they can telephone in their urgent work and this can be received by staff at 9 a.m. and 4.30 p.m.

Equipment

All midwives have the necessary equipment for their work and a gas/air machine each. There are eight Trilene apparatus and each midwife has an oxygen apparatus. Pethidine is used by all midwives. During the year the Central Midwives Board approved a new gas and oxygen machine for the use of midwives. We have now got 32 entonox machines, and a further number will be purchased in 1967. These have many advantages over the apparatus previously used by midwives.

Recruitment

This has improved during the year, and by basing midwives in towns the rural areas are now covered and the staffing position is satisfactory.

Retirements

Two full-time midwives and seven nurse/midwives retired.

Refresher Courses

The non-medical supervisors of midwives and all other midwives have to attend compulsory refresher courses every five years, and the county staff are all up to date in this respect.

Liaison

A midwife at Barnstaple visits the maternity units there to discuss with the ward sister early discharges, and she advises her colleagues in the, domiciliary field regarding these. More midwives are attending the doctors ante-natal examination sessions, and this is proving an advantage to all.

HOME NURSING

There are 32 full-time general nurses and 124 combining nursing and midwifery duties and 9 part-time general nurses.

Administration

Miss G. Heather, superintendent nursing officer, and her deputy and three assistants, are responsible for superintending the work of the nurses.

Recruitment

There has been some improvement in this, and on the whole the county is well staffed. Some home nurses are able to undertake some minor treatments to ambulant patients in the county health centres. This saves some travelling time and provides a valuable doctor/nurse link.

Retirement

Two home nurses retired.

Equipment

All hoists, lifting poles, wheel chairs, and walking aids have been in constant use during the year. Appliances are becoming more varied in type with newer rehabilitation methods, and increased stocks would appear to be necessary. There is a small waiting list for hoists.

The supply of incontinent pads has continued and is well worth the additional expense involved. We have received several letters expressing satisfaction about them and the staff are pleased, both with the quality and the delivery service of these pads. There has been no difficulty in disposing of the soiled pads. In towns where there are cottage hospitals, they are taken to the hospital incinerators, in country areas they are burned or buried in the garden.

Training

Two nurses were given Queen's district training during the year, and are now on districts giving good service.

Liaison

We continue to receive considerable help from voluntary agencies, and in particular I should like to say how much benefit is derived from the welfare grant and night sitting-in service provided by the Marie Curie Memorial Foundation for patients suffering from cancer.

The home nursing service continues to give considerable help to the elderly and infirm and the great majority of the work undertaken by the district nurses is now in the care of the elderly. This service is greatly appreciated as it makes for ease and comfort to the patients concerned and helps relatives looking after them. It also helps to keep people in their homes and relieves the pressure on geriatric hospitals, The caring for elderly people can be a most exhausting and wearisome task, and relatives are grateful for the services of the home nurses.

The additional help from voluntary organisations, especially the W.V.S. Meals on Wheels Service in providing hot meals, is of inestimable value as one of the greatest needs is good nutrition. So many of the aged are unable to cook, or even shop, and church workers and other associations contribute greatly in the urban districts in helping these people in a voluntary capacity.

Lectures in Hospitals

These were given by the superintendent or her deputy and assistants to to student nurses at the North Devon Infirmary, the Torbay Hospital and the Royal Devon and Exeter Hospital. Lectures were also given to student nurses undertaking district training arranged by Exeter City Council.

Trends

The work of the district nurses is summarised in the following table:

No. of medical cases nursed	11,062	involving	269,845 Visits
No. of surgical cases nursed	2,264	involving	45,052 Visits
No. of infectious disease cases nursed	17	involving	82 Visits
No. of tuberculosis cases nursed	49	involving	1,417 Visits
No. of maternal complications nursed	263	involving	1,679 Visits
No. of other cases nursed	471	involving	20,534 Visits

These figures include 10,078 patients over sixty-five years of age, who received a total of 237,880 visits; 315 children under five received 2,078 visits; and 2,847 patients who each received more than 24 visits in the year, the total number of visits involved to these patients being 156,485.

In 1966 the Queen's Institute of District Nursing carried out a survey of the work of the home nurse in selected areas, and it was stated that the specially trained nurse was often not using her skills fully. It is possible in some urban areas in the future further dilution of trained nursing staff may be necessary to carry out such duties as bathing, washing and dressing the aged and so release the trained nurse to care for persons discharged from hospital a few days after operation, and to relieve the pressure on hospital beds and Out-patient Departments.

Health Education

Civil Defence (Training in Nursing) Regulations, 1963.

During the year an increasing number of nursing staff have been engaged in the above courses. These consist of 5 sessions of two hours, the first two being undertaken by an ambulance officer, the following two by a home nurse and the last one being a joint session of the two above-named officers.

Nine of these courses were given to the general public, one to a Townswomen's Guild, 5 to senior pupils of County Secondary Schools, 2 to Young Farmers' Clubs, 1 to a Parent/Teacher Association, and 1 to a Women's Institute.

HEALTH VISITING

The Superintendent Health Visitor is based at the County Hall, Exeter. She is responsible for maintaining a high standard of health visiting including the organisation of the use and development of new ideas and procedures. She also has the important function of resolving the inevitable problems that arise from day to day with a large staff, and their personal happiness in their work.

At the end of 1966 there was an establishment of 91 health visitors including 3 vacancies. There was a marked delay during the year in filling vacancies and only 1 county sponsored student health visitor completed her training and started work. For the better co-ordination of work in this large geographical area the health visitors are divided into 10 groups which in size vary from 6 to 11 members and for the more rural areas this arrangement also

lessens any possible feeling of isolation. Each group has a Group Adviser who is herself a practising health visitor and she acts as a liaison officer to the whole group. She is responsible for co-ordinating the work of the group. This includes arranging reliefs for absences due to holidays or sickness and for introducing new members of the staff to colleagues concerned with the health and welfare of the community in her area. She also ensures their knowledge of the particular methods of work in this authority. The Group Adviser has further responsibilities in arranging the practical training of the many students who come to Devon for their field work experience. All these aspects of her work include a large element of positive health education which is more and more recognised as being a most important part of the daily work of the health visitors.

All infants are visited as soon as possible after the 10th day, and further visits are made at intervals up to the age of 5 years. In the early weeks infants are examined for possible dislocation of the hips and the urine is tested for phenylketonuria. At six to eight months there is a simple hearing test; where there is any doubt a further visit is paid to retest and if necessary the child referred to the hearing assessment clinic. The health visitor is sometimes the first person to recognise that a child has a mental or physical handicap. She co-operates with the family doctor and other workers so that arrangements may be made to enable the child to make the best possible use of all faculties, and to diminish, whenever possible, the effects of any handicap. A health visitor attends the premature baby outpatients in the Exeter area once weekly. Another member of the staff visits the premature baby unit once weekly to see that full information is available for follow up of infants.

Health visitors and midwives together teach relaxation and mothercraft in the ante-natal clinics. In some parts of the county very successful classes for fathers have also been organised in the evenings. In the child welfare centres the health visitor advises the mothers individually and also carries out group teaching when possible. She assists the medical officers by her knowledge of the home background. The prevention of the spread of infectious diseases is one of her most constant duties and by stressing the need for immunisation and vaccination she endeavours to see that as many children as posible are protected. For some years the health visitors have assisted the chest physicians to trace unknown cases of tuberculosis in the county by Heaf testing school-children annually from the age of 5–11 years. The contacts of positive reactors are traced and endeavours made to persuade them to attend for X-ray. From the 1st December, 1966, this was reduced to school entrants only.

In the School Medical Service the health visitor is responsible for visiting the schools in her area; assisting in medical procedures such as school medical examinations. She sees that all school-children have periodic vision tests, hearing tests and hygiene surveys. She is also available to help teachers to understand the home background of children who present a problem. Home visits are paid to parents of school-children when necessary, special support being given to the families of handicapped children. Junior Training Centres and the school for physically handicapped children are also visited. The homes of handicapped children at residential schools are visited during the school holidays so that any problems may be discussed. The health visitors have assistance from clinic nurses in routine work in schools and clinics.

There are a large number of child minders and play groups in the county area and they are notified to the health visitor who visits at three-monthly intervals.

There is in the county a hard core of problem families, and the health visitors use every means in their power to try to improve the conditions in

which these families live. Good team-work is an essential factor in the attempt to rehabilitate them, and there is close work at field level between the statutory and voluntary workers concerned with the differing facets that are shown in such cases.

The health visitors assist the Children's Officer by providing reports on prospective adopters and foster-parents.

Hospital consultants and almoners often request reports on home circumstances for patients with special problems who are ready for discharge. Over the years there has been a steady increase in the number of home visits paid to the aged. In some areas health visitors have carried out or taken part in surveys to discover the number of people over the age of 65 years who live alone. There still remains the need to extend this work because of the high number of aged in this county. There is a good relationship between health visitor and hospital medico-social workers who contact each other directly.

In some senior schools programmes of health education are carried out by health visitors. They co-operate with the current campaigns such as rescue breathing, smoking and lung cancer, etc., in schools, clubs and other organisations. Many assist with the Duke of Edinburgh's Award courses. In a few Senior Schools the health visitor is available at a specified time—usually the lunch hour, so that any child may ask advice on personal problems. Talks are given to organisations when required.

Students from hospitals, health visitor training schools, universities, and teacher training colleges accompany health visitors for varying periods for purposes of observation and practical work.

With the exception of one health visitor everyone is a car driver and so is able to get about her area with the minimum of travelling time. As each health visitor is on the telephone at home she can be contacted in emergencies by members of the public, doctors, or other workers.

Refresher courses are attended by health visitors every five years. In-service training is also given in the form of study days, attendance at lectures and visits to mental hospitals etc.

Liaison with general practitioners has improved steadily over the years and generally there is a good working relationship. 68 health visitors now have their case loads based on the families in group and single practices instead of geographical areas. They carry out their usual duties but there is also improved facilities for two-way co-operation between the family doctor and the health visitor attached to his practice. This results in closer co-operation and mutual benefit in their work of family care. A number of doctors have expressed appreciation of the help given particularly in relation to the health and social problems of the older patients. There are difficulties in that health visitors have high case loads and some practices cover a wide territory. Health visitors also assist family doctors who have their own well-baby clinics.

In areas where there is a County Council Clinic (Barnstaple, Bideford, Buckfastleigh, Crediton, Dartmouth, Dawlish, Exmouth, Holsworthy, Honiton, Ilfracombe, Kingsbridge, Lynton, Newton Abbot, Okehampton, Paignton, Plympton, Plymstock, South Molton, Tavistock, Tiverton, Torquay) health visitors may be contacted between 9 a.m.–9.30 a.m., at the clinic. In the larger clinics where a clerk is employed, messages may be left to be dealt with by the health visitor. Each health visitor is issued with visiting cards which show her home as well as any official address and telephone number. One of these cards is given to a family at a first visit. A new health visitor visits general practitioners and social workers as soon as possible after taking up her duties.

A summary of the work undertaken by the health visitors during 1966 is given below:

Type of Visit	*No. of Visits*
Infants under one year	50,426
Children one to two years	20,163
Children two to five years	36,424
Schoolchildren	9,610
Age groups fifteen to sixty-five years	16,648
Expectant mothers	4,981
Tuberculosis	977
Aged	12,650
Mentally disordered persons	1,819
Under Children's Act	1,621
Patients discharged from hospital (not mental hospitals)	400
Attendances at centres, clinics, etc.	8,158

HOME HELP SERVICE

Administration

Mr. G. P. Brooks, the County Organiser, works from County Hall, Exeter, and is responsible for administering the service throughout the county through eleven area organisers and their assistants. They are based at major clinics in each of the M.O.H. areas. At the end of 1966 there was one W.V.S. organiser —responsible for the service at Dartmouth C.B. All accounts relating to the service are raised in the health department and the county organiser is responsible for the collection of accounts by full-time collectors.

The service in 1966

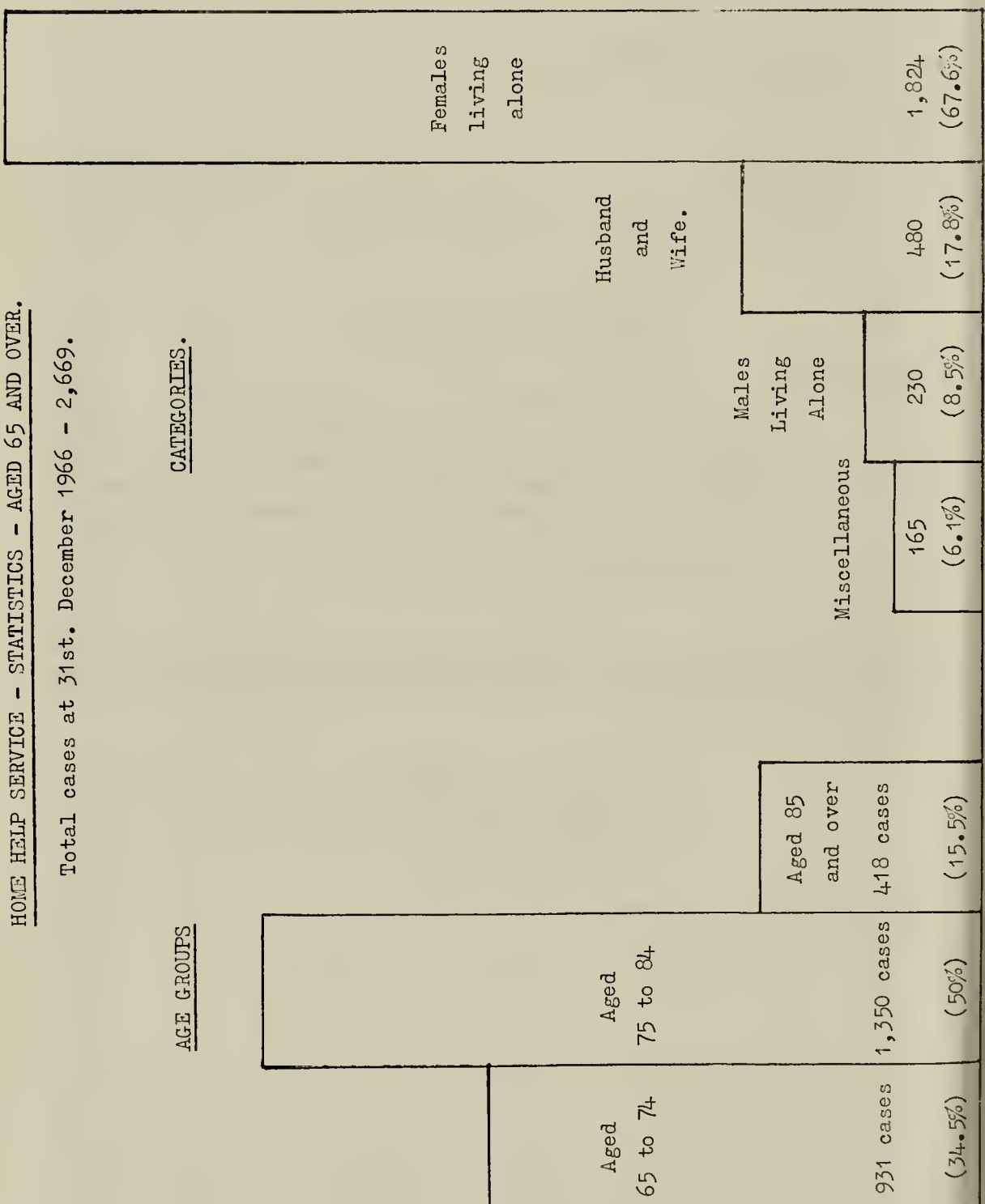
During 1966 the demand for the service continued to increase and details of the 5,174 cases dealt with in the twelve month period ended 31st December are given in the following table:

	Over 65	Under 65			Others	Totals
		Chronic Sick inc. T.B.	Mentally dis-ordered	Maternity		
D.C.C. Organisers	3,751	419	41	481	437	5,129
W.V.S. Organiser	55	3	—	3	4	45
	3,786	422	41	484	441	5,174
Figures for 1965	3,555	412	49	497	403	4,916

At 31st December there were 1,190 Home Helps employed—all part-time. Full-time equivalent—370.

The daily case-load at 31st December was 3,216 compared with 2,954 the previous year and of this number 2,669 were concerned with the care of the "over 65" group—82 per cent (in 1965 the corresponding figures were 2,395—81.5 per cent). The proportion of cases in this group has remained virutally unchanged for the past six years in spite of the rapid over-all growth of the service.

The following graph illustrates the distribution of these 2,699 cases in (a) age groups and (b) categories. In (a) 50 per cent of the cases were in the middle group—aged 75–84. In (b) it is very interesting to note the high proportion of females living alone.



For every male (230) there were 8 females (1,824) and the combined total of these single-person households (2,054) made up 76.1 per cent of the total. This means that rather more than 3 out of every 4 persons assisted, aged 65 and over, were living in single-person households, and gives some indication of the individual care being given to this group of the elderly.

The changing pattern in 1966

(1) Administrative areas: In June of 1966 a new pattern of administrative areas was introduced. The eleven main areas were reduced to six—five having senior organisers controlling larger districts, with a consequent interchangeability of organisers within the larger units. This will afford a better opportunity for the in-training of assistants and a continuity of service covering sickness, holidays etc. The organisation should be more efficient and economical under the new scheme.

(2) Boundary changes in 1966: April 1st saw the transfer of certain areas from St. Thomas Rural District to Exeter C.B. This involved a smooth and simple transfer of cases and home helps and in view of the comparatively small number involved, did not create any staffing problems as these had been anticipated in the re-organisation of areas referred to in (1) above.

(3) Transfer of former W.V.S. areas to county staff: Following the resignation of three W.V.S. organisers the following areas were transferred to Devon county full-time organisers at the request of, and by arrangement with, the W.V.S. county organiser: Axminster, Seaton and Teignmouth. The reorganisation mentioned above was effected without any establishment or staffing changes. One W.V.S. organiser continues to run the service at Dartmouth. The work of these ladies has been of inestimable value to the service.

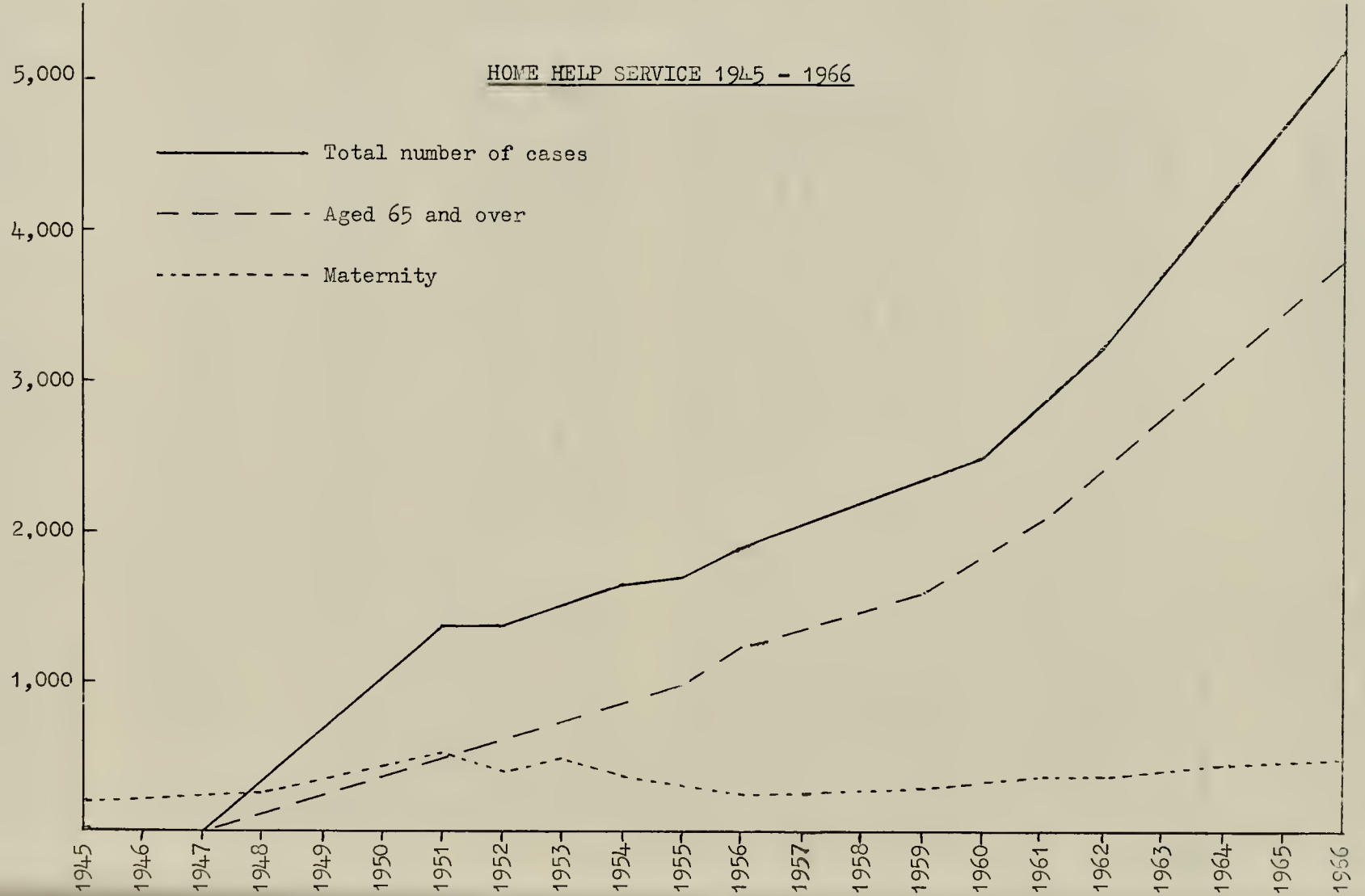
(4) Assessment of cases (contributions): In September the assessment of eases was transferred from the Education Department to the HealthDepartment. This enables a provisional assessment of the contribution to be made in the field, usually at the initial interview. This has many obvious advantages. Assessments are checked in the health department and confirmed by letter to the household. Out-of-the-ordinary cases are referred to the County Treasurer for consultation. At the end of the year the new scheme was working very well indeed.

(5) Ministry of Social Security (formerly National Assistance Board): on the 28th November the Ministry of Social Security came into being, replacing the National Assistance Board. The transfer of assessments in September had brought the Home Help Service in close liaison with officers of the N.A.B. and this has continued with the new ministry.

(6) Collection of accounts: The process of transferring the collection of accounts from Education Welfare Officers to full-time collectors in the health department was completed in March. Later it was agreed that accounts for children at the Basildon Home, Exmouth should be dealt with by the H.H. Service collectors.

Growth of the Service

The history of the service in Devon is given in graph form on page 60. The years 1945–1947 show the maternity service then in being before the implementation of the 1946 Health Act in 1948.


HOME HELP SERVICE 1945 - 1966
Total number of cases
Aged 65 and over
Maternity
5,000
4,000
3,000
2,000
1,000
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966

It will be seen that in the 6-year period 1960–1966 the service has more than doubled from 2,514 to 5,174 cases.

In-training of field staff

Home help organisers have their own Institute at national level, recognised by the Minister of Health. Hitherto full membership was given to associates and others, following a course of study organised by the Institute, and the passing of an examination. Associate membership is open to all organisers and assistants. The certificate of the Institute was given to successful examination candidates. This has now been taken a step further and a course of study, followed by examination, has been arranged by N.A.L.G.O. This is mainly concerned with central and local government and certain aspects of the service—up to inter D.M.A. standard. Courses may be arranged locally in conjunction with correspondence courses arranged by N.A.L.G.O.

The Royal Society of Health now offers full and associate membership to organisers who are suitably qualified, or on examination. At present we have two full members and one associate member. Seven organisers hold the certificate of the Institute and three are taking the present course. One organiser has been accepted for a Diploma in Social Studies course in 1967.

It has not been found necessary to institute any form of organised training for home helps who are in the main experienced housewives. Periodical evening talks are arranged by organisers—and also social events.

Liaison with doctors and hospitals

All general practitioners, medical social workers in hospitals, staff of the health department and all concerned with domiciliary care are informed of the address and telephone number of the home help organiser for the particular district in which a person requiring the service resides. Notice of any changes is given whenever necessary. One of the main factors contributing to the rapid growth of the service in recent years has been the demand made by general practitioners.

Enquiries regarding the service

Reference has already been made to the fact that all doctors, hospitals, members of the staff of the health department, etc., are informed of the address and telephone number of the local organisers. Alternatively, an enquiry addressed to the County Medical Officer, County Hall, Exeter, will be forwarded to the appropriate organiser. In urgent cases enquiries can be dealt with by telephone.

I wish I could do it myself !

Everybody's busy

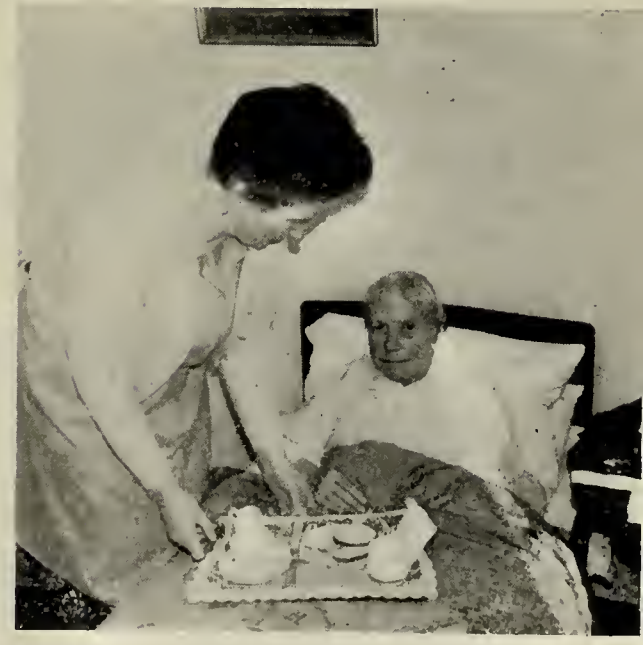
Come on.....you can do it!

Good Companions

Keeping up appearances

At work in a caravan

Mmm.....it smells good!



A dainty tea

HOME HELPS IN ACTION

HEALTH EDUCATION

The health education unit has continued to provide material, instruction and co-ordination for those engaged in health education in the field. The amount of help given was once again an increase on previous years.

Exhibitions

The Devon County Show exhibition was replaced this year by smaller local exhibitions. These were felt to be more useful, and will become a regular pattern to give the public more knowledge of health in action.

Smoking and Health

Once again a topic of great importance which is very difficult to get across to youth. Schoolchildren have once again been the audience at which the information has been mainly aimed.

Venereal Disease

This is a subject which is discussed when a request is received and discussion is led by a medical officer or health visitor who can give information together with other matters such as personal relationships.

Dental Health

The programme being introduced as lessons in primary schools and to ante-natal classes are creating great interest and are apparently producing a more lasting effect and greater appreciation of the need for dental care than hitherto.

The new talks are very acceptable to teachers, many of whom have expressed willingness to do "follow up" sessions after the dental hygienist's visit.

Accident Prevention

There is still great concern with the number of accidents. During the year, posters and leaflet information have been sent regularly to clinics and health centres, pointing out the manner in which accidents take place and the means by which they can be prevented. There is a great deal of work to be done if the information is to get across to the public, and for the correct action to be adopted in the home, on holiday, at work and play.

In-Service Training

Courses for health department staff are being discussed and planned. This unit continues to give full support during the planning and running of such courses, and lends, equipment and material to promote a greater interest in the subject content.

A course of talks, group discussions and socio-drama has been arranged for health visitors in north Devon. This will include special reference reading and case work reports, The series is designed to help the group improve expression, interpretation, interview and case-history recording.

Rolle College, Exmouth (for women student teachers)

The questionnaire mentioned last year has provided much information which will be useful to future planning. The student teachers certainly are eager for more health education information especially on subjects such as accident prevention and first aid.

Occupational Therapy Filmstrip

This filmstrip "Towards a Fuller Life" made its appearance this year and has been well received by occupational therapy training schools and careers exhibitions. The publicity received has been most encouraging and has made the effort worthwhile.

Health Education Students

Devon has again been used as a field placement for Health Education Diploma students of London University. This year the visit was divided into two separate parts, observational work and practical work.

Talks

General

Apart from ante-natal and welfare sessions 1,579 talks were given as follows:

Headquarter staff	65
A.C.M.O.s	3
Health visitors	1,102
District nurses/midwives	6
Dental officers	2
Dental auxiliary	65
Dental hygienist	284
Occupational therapists	6
Social Workers in Mental Health	24
Chiropodists	2
Speech therapists	6
Adult workshop managers	1
Home help organisers	3
Ambulance section	10
	1,579

Ante-natal classes

1,615 talks were given to expectant mothers during the year, of these, midwives gave 920 and health visitors 695. Some talks were given by commercial representatives and the dental hygienist.

Film bookings

Single bookings and film hire (excluding number of showings)	491
Bookings of filmstrips, sound filmstrips, slides (excluding those used and based in 4 areas, and the number of showings)	283
Bookings of cine projectors (number of times used not indicated)	369
Bookings of 35 mm. projectors (number of times used not indicated)	253

A marked increase compared with last year.

Trainees and students on observational visits

Social work students	11
Occupational therapy students	13
Health education students	2
Trainee district nurses	11
Student nurses (accompanying health visitors)	48
School leavers	49

These have been placed by the Universities of Exeter, London and Bristol, Technical Colleges in the south west and other colleges.

Foreign Students

Local Government Officers (from Australia, Swaziland, Eastern Nigeria and Jamaica)	5
World Health Organisation Fellowship Students (from Brazil and Japan)	2
Doctors studying the Dip. Public Health (from Norway and Syria)	2
Fellowship student for U.N.S.W. (from Poland)	1

THE AMBULANCE SERVICE

Section 27 of the National Health Service Act, 1946, places on local health authorities the responsibility of providing ambulances and others means of transport, where necessary, for the conveyance of persons suffering from illness, or expectant and nursing mothers, from places in their area to places outside their area. The words "where necessary" are generally interpreted as meaning the provision of transport to or from the nearest hospital at which the treatment required by the patient can be given assuming the patient is unfit by reason of mental or physical disability to travel by public transport. A further provision under section 27 allows local health authorities to delegate the provision of an ambulance service to the voluntary organisations.

The Devon County Council have taken advantage of this provision and have been very fortunate in being able to rely on the voluntary organisations of St. John, the British Red Cross Society and the hospital car service, to provide the service on their behalf.

The county council have entered into agreements with 32 local voluntary organisations in the county. Twenty-five of these organisations are St. John, five are Red Cross, one is a joint committee of St. John and the Red Cross and the other is an *ad hoc* committee made up of local people. This agreement provides for the local association to appoint and train such whole-time personnel as may be required to run the service in addition to the considerable number of voluntary members. All full-time personnel, therefore, are the employees of the local association, but the county council reimburse all running expenses of the ambulance service including staff salaries, provision of office equipment, the upkeep of vehicles, lighting, heating, rents and national and other approved insurances. The county council also provide the uniform for the full-time personnel. The number of vehicles owned by the associations has dropped from forty or so in 1948, to three at the present time, and it is the county council's policy to replace all locally owned ambulances by one provided by the county council. The county council now own sixty-three of the sixty-six ambulances used on ambulance work. A provision of the agreement is that officers of the county council can inspect vehicles, premises, and personnel at any time. It is part of the county ambulance officer's terms of appointment to be responsible for encouraging and fostering the voluntary effort as far as possible and to ensure that whatever aid is required by the local associations in order to carry out their duties under the agreement, is given. Until the end of this year he has been assisted in this task by the ambulance liaison officer, who was appointed by St. John and the Red Cross to look after their interests, and to liaise with the county ambulance officer. There is no doubt that this arrangement has resulted in Devon being able to rely on the voluntary organisations to run their own ambulance service much longer than has been possible in other authorities. Complaints concerning the service are reported both to the head of St. John or the Red Cross and the county medical officer, who between them decide what action to take to remedy any shortcomings.

I do not think it is generally appreciated how much voluntary work comes into the provision of the ambulance service. Whilst a small call-out fee is paid to volunteers for the time they are actually working on the ambulance, no payment whatsoever is made for the enormous number of hours they stand by waiting for a call. There is also a large amount of voluntary work carried out by the officers of the voluntary organisations in arranging rosters, training, etc.

The majority of the sitting case work is carried out by the hospital car service. This consists of a number of private car owners who put their services

at the disposal of the ambulance service. Nothing is paid to these drivers for the time they put into the service, but they do receive a small mileage allowance, which is agreed nationally, to cover cost of petrol, oil, and fair wear and tear.

Mention must also be made of the work put into the hospital car service by the area transport officers who receive all requests for sitting case transport, and who organise the journeys which are required. These persons spend a tremendous amount of time on this work and except for a very small clerical allowance do the work voluntarily.

The people of Devon should be grateful and proud of the fact that there are so many public spirited individuals available in the county to keep the ambulance and hospital car service working on these lines.

There are thirty-two ambulance stations in the county and they have been organised under four area controls at Barnstaple, Exeter, Plympton, and Torquay. These areas are more or less co-terminus with the catchment areas of the hospitals which they serve. By this means the majority of the ambulance journeys in one control area are made towards the focal point, namely the main hospital for the area. This lends itself to a better co-ordination of journeys. All ambulances and controls are equipped with two-way radio.

Emergency Calls

All emergency calls on the ambulance service are connected direct to the appropriate control office by the telephone service. It is important, therefore, that persons making an emergency ambulance call should carry out the instructions on the disc of the telephone upon which the call is made. In most parts of the county this means dialling 999.

Long Distance Journeys

British Rail provide excellent facilities for the transfer of stretcher and sitting cases. It is not generally appreciated that a stretcher case can travel much more quickly and comfortably by rail than by other means and that a special stretcher is available to ensure that the patient is able to travel the whole journey from door to door on one stretcher without being moved.

Infectious Diseases

Arrangements for the transport of patients suffering from infectious diseases are made from the following stations:

Torquay, Plympton, and Barnstaple,

and in the case of East Devon by the Exeter County Borough ambulance service.

Smallpox

As the only smallpox hospital in this area is at Liskeard, Plymouth County Borough has undertaken to deal with any smallpox cases which might arise in the county.

Premature Baby Incubators

Premature baby incubators are kept at Torquay, Plympton, Barnstaple, and Honiton ambulance stations, and can be obtained by telephoning the appropriate ambulance control office.

Emergency Flying Squad

An ambulance is placed at the disposal of the emergency flying squad at the Torbay Hospital as and when required.

Agency Arrangements with Exeter County Borough

The Devon County Council have entered into an agency arrangement with the Exeter County Borough Council whereby Exeter undertakes the provision of an ambulance service in those parts of Devon adjacent to Exeter and Devon undertakes the administration of the hospital car service within the City of Exeter. Appropriate financial adjustments are made.

Air Transport

The arrangement for the transport of patients by air is covered by a Ministry of Health circular on the subject. The Minister's views, with which the County Council agrees, is that air transport should be used only in those cases where the local authority, on the advice of the Medical Officer of Health, is satisfied, after consultation with the medical practitioner (normally the Consultant) in charge of the case, that it is essential on urgent medical grounds, and that all other forms of transport have been considered and found to be impracticable. It is not thought that such cases will often arise. The County Council have been quite firm in their decision that they will only meet the cost of transporting patients by air when the authority's prior approval has been obtained.

Statistics

	1965	1966
Ambulances		
Patients	78,443	80,238
Emergencies	9,229	8,674
Mileage	837,619	863,090
Hospital Car Service		
Patients	273,429	296,157
Mileage	2,666,924	2,780,691
Hired Cars		
Patients	7,500	7,222
Mileage	28,697	27,398
Totals		
Patients carried	359,372	383,617
Mileage	3,533,240	3,671,179

999 Ambulance Calls Received

1.1.65–31.12.65

Ambulance Control	Road Accidents	Collapse Cases	Overdoses	Others	Total
North	284	151	15	250	700
Mid/East	562	136	13	316	1,027
West	280	103	37	297	722
Torbay	821	679	58	950	2,508
Total	1,947	1,074	123	1,813	4,957

1.1.66.–31.12.66

North	282	162	19	285	748
Mid/East	594	160	15	329	1,098
West	296	133	26	315	770
Torbay	848	816	70	1,089	2,823
Total	2,020	1,271	730	2,018	5,439

The overall figures for the total of patients carried and mileage run show an increase of 6.7 per cent and 3.9 per cent respectively whilst the miles per patient has fallen from 9.8 to 9.5. There has also been a 9.7 per cent increase in the number of "999" calls received.

Boundaries

From the 1st April, 1966, certain areas in Alphington, Pinhoe and Topsham were taken over by Exeter County Borough. This change made little if any difference in the operation of the service as the ambulance service in the areas concerned was already provided by the Exeter County Borough in accordance with the agency agreement with that authority. Devon County Council continues to administer the Hospital Car Service for the enlarged area under the same agreement.

Staff

As a result of the introduction of the forty hour week for all full-time ambulance staff, it was found necessary to appoint extra men at Kingsbridge, Newton Abbot, Plympton, Tavistock, Torquay and Totnes ambulance stations.

Safety

During the course of the year flourescent waistcoats for use by ambulance staff when attending road accidents in dark or misty conditions have been issued. Fog lamps have been installed on all ambulances and a decision has been taken to equip all ambulances with safety belts.

Liaison With Hospitals

Meetings have been held with the staffs of the Mid-Devon Hospital Group, the West Devon and East Cornwall Hospital Group and the Torbay Hospital Group. There have been useful exchanges of views on matters affecting the ambulance service.

The recommendations of the Platt report on the Accident and Emergency Services have been implemented in the Mid-Devon Hospital Group and the arrangements are working well.

Training

The issue of the Working Party Report on Training has highlighted the need for more advanced training in the changing pattern of the National Health Service, following the Platt report on the Accident and Emergency Service. More advanced training is also necessary in order to keep pace with progress and discoveries in the field of medicine. At the moment the training of ambulance personnel in Devon is the responsibility of the voluntary aid societies, but there is provision in the agreement for any training required being given by me or such person as I may designate. There will be no need, therefore, for the agreement to be amended before we embark on whatever training

scheme the Minister may decide upon as a result of this working party's recommendation.

Christmas Holiday Period

Despite the national picture of a large increase in road accidents over the Christmas holiday, the number of "999" calls which the ambulance service had to deal with for the period 24th to 27th December inclusive fell from 54 in 1965 to 33 in 1966—a drop of almost 40 per cent.

Ambulance Liaison Officer

Mr. W. C. Johnson has acted as Liaison Officer between the voluntary aid societies and the County Council for the last ten years. During this period the relationship between the County Council and the voluntary organisations has improved to such an extent that the need for a liaison officer no longer exists and Mr. Johnson has decided to retire. One of the main reasons for this happy state of affairs is the work which Mr. Johnson has carried out so conscientiously over the last ten years. The County Council and the voluntary aid societies owe him a debt of gratitude.

Publicity Campaign

The Ambulance Sub-Committee expressed their concern at the ever increasing number of occasions that emergency services are tied down in dealing with foolhardy individuals who put their lives, and the lives of their rescuers, at risk by attempting cliff climbs without the necessary experience, and by bathing in dangerous waters when red warning flags were flying. District Councils have been reminded of the powers they have under Section 231 of the Public Health Act, 1936, to make byelaws regulating bathing. It has also been suggested to them that notices at the foot of cliffs which the public may be tempted to climb may do some good. Neighbouring County Councils have been asked to join in a combined publicity campaign on these subjects.

The Voluntary Aid Societies and the Hospital Car Service

Sincere thanks are due to the members of St. John, the British Red Cross Society and the Hospital Car Service for the tremendous amount of work which is done by them in carrying out the work of the ambulance service in Devon. The number of patients carried increases year by year but these willing helpers always manage to keep up with the growing demands on their services.

Civil Defence

The final round of the first County Competition for the Ambulance and First Aid Section was held in March. Over two hundred spectators saw the Paignton team win the cup.

Very good progress has been made with the provision of courses in the first aid and home nursing for members of the public under Ministry of Health Circular 9/63. Nineteen such courses were held during the year and a total of 268 persons attended.

The delay in the issue of the Government's plans for the re-organisation of civil defence has given volunteers a sense of insecurity but nevertheless training has gone ahead very successfully during the year.

THE CARE OF THE ADULT HANDICAPPED

The expansion of the adult health section continues. Some of the new developments over this period are as follows:

1. The Doyle Adult Training Centre at Salterton Road, Exmouth was completed. This purpose-built training centre is for 90 trainees and will replace the centre at present held in the All Saints Church Hall.

2. Plans for the new adult training centre at Tavistock to provide 50 places have been approved by the Ministry of Health and specifications for tender are nearing completion.

3. The Ministry of Health have approved plans for a new adult training centre. and hostel for the adult subnormal, at Axminster.

4. The training centre at Kingsteignton is now open on 5 days a week at St. Columbas Hall instead of 2 days a week in Newton Abbot as previously.

5. The training centre formerly at Axminster has moved to Colyton in more satisfactory hired premises and is open on 5 days a week instead of 3 days a week as previously.

6. Sites for future projects have been acquired as follows:
   (*a*) a halfway home at Hawley, Barnstaple for 15 short-stay residents who have been in-patients at a psychiatric hospital.
   (*b*) adult training centres and hostels at Kingsbridge and Holsworthy.

Social Workers in Mental Health

A comprehensive community care service for all types of mentally disordered adults has been in existence for many years in the County, and the field staff this year has been increased to 26 area social workers and 2 trainee social workers. The social workers are based on 16 centres throughout the County which is divided into 4 areas. These areas cover the catchment areas of a psychiatric hospital or of one of the proposed psychiatric units which are to be attached to the Barnstaple and Torbay hospitals where outpatient clinics are already in existence. The four areas are:

(1) East and Central Devon (Exe Vale Hospital with additional outpatient facilities at Exeter and Axminster).

Social workers based at Budleigh Salterton, Crediton, Exeter, Honiton, Okehampton and Tiverton.

(2) North Devon (Barnstaple outpatient clinic with additional outpatient facilities at Bideford).

Social workers based at Barnstaple, Bideford, Ilfracombe and South Molton.

(3) West Devon (Moorhaven Hospital and the associated Nuffield Centre at Plymouth).

Social workers based at Plymstock, Kingsbridge and Tavistock.

(4) South Devon (Exe Vale Hospital and Torbay Hospital outpatient clinic with additional outpatient facilities at Newton Abbot).

Social workers based at Paignton, Torquay and Newton Abbot.

Total Case Load (all types of Mentally Disordered Persons)

	1962	1963	1964	1965	1966
Total Case Load	2,135	2,407	2,469	2,543	2,556

The active individual case load of social workers is large and although the number of social workers employed is increasing annually, we have never been able fully to satisfy the demand for community care.

Visiting and care of the mentally retarded children in this County is provided mainly by the health visitors. The social worker is called in where there are special problems or to arrange admission to a psychiatric hospital. This arrangement is economical in manpower since the health visitor is often visiting the home of the handicapped child, either to see another child of the family or perhaps an older relative.

Analysis of Referrals to Social Workers

Sources of referral of all categories of new patients	1962	1963	1964	1965	1966
General Practitioners ..	539	747	736	979	1,217
Hospitals, on discharge ..	291	380	626	539	529
Hospitals, Out-patients Dept.	276	386	449	437	330
Police and Courts	47	54	44	72	146
Other Sources	251	341	267	313	300
Total referrals ..	1,404	1,908	2,122	2,333	2,522

These figures give a very clear indication as to the growth of the community care service.

Moorhaven Hospital (for the Mentally Ill)

Dr. F. E. Pilkington, Physician Superintendent of Moorhaven Hospital, in his annual report states:

"There have been considerable changes in the pattern of care for mental illness. The changes are characterised by a substantial increase in the number of admissions to psychiatric hospitals, a faster rise in the number of discharges leading to a reduction in the average length of stay and, since 1954, a fall in the total number of in-patients in hospitals treating the mentally ill. The rise of the first admission and discharges, however, does not result in a corresponding increase in the number of patients receiving hospital care because the numbers of re-admissions are increasing still faster. In 1951, first admissions represented nearly two-thirds of the total admitted and second and third admissions under one-third. Less than one-tenth had more than three previous admissions. By 1960, the proportion of first admissions had dropped to just over half the total: second and third admissions accounted for one-third while one-fifth of those admitted in 1960 had more than three admissions."

"The total number of beds in the Hospital Group is 761, distributed as follows:

Moorhaven Hospital	678 beds
Moorfields Hospital	58 beds
The Gables Hospital ..	25 beds

This is the same number as last year".

"The catchment area remains unchanged, viz., the County Borough of Plymouth and the following parts of the County of Devon—Plympton St. Mary Rural District, Tavistock Rural District, Kingsbridge Urban and Rural Districts and Salcombe Urban District, together with the parishes of Ugborough, South Brent, North Huish, Diptford, Morleigh and Halwill in the Totnes Rural District. The population is estimated at 304,730 and so this gives us 2.5 beds per thousand of the population. Patients are occasionally admitted from outside the catchment area, but only if there are special reasons, and provided there are sufficient beds available so as not to prejudice admissions from the official area."

"The number of beds is barely sufficient for our needs and, indeed, there is often unavoidable delay of many weeks before a bed can be found for a geriatric patient, especially on the women's side. Occasional bed crises arise in other parts of the Hospital too."

Exe Vale Hospital Group (for the Mentally Ill)

Dr. Lewis Couper, Medical Co-ordinator-Consultant Psychiatrist, Exe Vale Hospital Group has reported as follows:

"Co-operation of social workers in mental health with the three sections of Exe Vale Hospital continues on a friendly basis. The outstanding problem at the moment is to arrange for better communication from the hospital social work department to the social worker in the County in order to assist in the placement of patients returned to the community. It is hoped that his problem will be resolved in the reasonably near future with the joint appointment of a social worker to cover this aspect.

"Liaison established between the County mental welfare officer and th Hospital Group is good and we are fortunate to have such understanding between us."

Mental Illness

No. of Social Workers Visits	1962	1963	1964	1965	1966
Known mentally ill adults in the community	1,286	1,480	1,560	1,673	1,505
Visits to patients	11,271	12,620	14,415	17,868	20,599

Social Worker Visits in respect of Hospital Admissions and Discharges of the Mentally Ill

Mental Health Act 1959	Exe Vale Hospital	Moorhaven Hospital	Out-County Hospitals	1962	1963	1964	1965	1966
Informal Patients (Sect. 5)	1173	83	7	1279	1198	1537	1471	1263
Observation (Sect. 25)	171	17	0	110	126	131	151	183
Treatment (Sect. 26)	14	16	0	11	25	19	17	30
Emergencies (Sect. 29)	331	17	1	322	283	294	312	349
Courts (Sect. 60)	10	0	0	4	14	12	19	10
Total Admissions	1699	133	8	1726	1646	1993	1070	1840
Total Discharges	1297	50	5	1355	1514	1803	1604	1332
*Re-admissions (included in the totals)				602	482	717	519	281
Visits by social workers in respect of admission				3247	3477	3706	4090	3929

The de-centralisation of social work services has proved satisfactory. The senior area social workers are responsible for the day-to-day administration of the service in their particular area and are co-ordinating the work of their social workers in order to provide economy of individual effort.

Social Work Training

The Health Committee encourages the further training of staff. During the year two officers attended Council of Social Work Training Courses and one a course leading to qualification as a psychiatric social worker. One social worker returned from a Younghusband Course having obtained his Certificate in Social Work. In addition, one social worker was accepted as a part-time student at the University of Exeter to read for his Diploma in Social Administration. This University uses officers of the department as placements for its graduate students and Moorhaven Hospital also uses these facilities in connnection with social worker students. The section's services as a whole are used by Exeter University to give their students a general insight into the working of the social services. The trainee mental welfare officer appointed last year proved most satisfactory and has been appointed a full mental welfare officer, taking up an establishment vacancy. This officer is now completing a part-time course of study at the University of Exeter. The St. Loyes School of Occupational Therapy send occupational therapist students to the department for placement as part of their training.

Medical officers, social workers, occupational therapists and training centre staff continue to give lectures to various associations and societies who are interested in the work carried out within the department.

Voluntary Organisations

The Women's Voluntary Service offer their visiting service in association with the psychiatric hospitals and social workers in mental health. The members visit patients in hospital and, with the consent of the patient, at home after they have been discharged.

The Club run by the W.V.S. at Exminster Hospital maintains its popularity with the patients, and fulfils a most necessary function in operating a trolley shop which visits about twenty wards on four afternoons each week.

The shop and canteen at the Royal Western Counties Hospital, Starcross, continue very successfully.

Royal Western Counties Hospital (Care of the Mentally Subnormal)

Dr. D. Prentice, Medical Superintendent and Consultant Psychiatrist, reports:

"The Royal Western Counties Hospital Group continues to provide care and training under medical supervision for about 1,700 mentally disordered patients, most of whom suffer from a degree of subnormality as defined in the Mental Health Act, 1959 whilst one or two have been admitted from the Courts more recently suffering from psychopathic disorder.

"The largest hospitals in the Group are at Starcross and Langdon, near Dawlish. At Langdon there are now 556 beds and at Starcross 553. At present under construction is a new villa (2 by 30 beds) at Langdon. At these hospitals patients and staff are engaged in a wide variety of activities under the supervision of the nursing, artisan, catering, occupational and industrial therapy, agricultural and horticultural staffs. Many of the patients, after going through the training scheme, go to employment locally on a daily basis and one of the added problems is the Selective Employment Tax which has had an effect on the amount of outside employment secured.

Recreational activities are varied as much as possible and include regular games instruction, whilst matches are played on first-class cricket, football and hockey pitches. Patients who are able, enjoy swimming, country dancing and netball. The usual indoor entertainment such as shows, cinema and television, billiards and snooker are available to patients.

There are also eight similar units in Devon and Cornwall, three of them over 100 beds being Box House Hospital, Axminster; Western Hospital, Crediton and the Retreat and Treleigh Hospitals, St. Columb Major. Three of the hospitals are designed for the care of a particular class of patient: Franklyn Hospital, Exeter mostly for cot and chair children; Stoke Lyne Hospital, near Exmouth for ambulant boys and the Elizabeth Barclay Hospital, Bodmin for geriatric patients. In October an additional 16 beds were provided at Franklyn Hospital. There are two hostels for male patients who are being trained for farm situations, a female hostel at Paignton for patients nearing return to the community and able to undertake domestic employment daily. There is a holiday home at Teignmouth for female patients and a summer Holiday Camp at Brixham which is occupied fully from late May until early September each year. During the holiday periods, more particularly in the summer when a number of patients go to their own homes, it has been found possible to offer short-term care to mentally subnormal persons who are normally looked after by their parents. This affords relief for holidays to be taken.

"The Hospital Group has always regarded hospital and community care as complementary to each other and, while individual patients may be adequately trained in one or the other, many require and benefit from their combined services in enabling them to develop their full potential. Thus a close integration of the activities of both is essential if efficiency is to be achieved in the best interests of the patients concerned. This integration is effected by regular liaison and co-operation between the Hospital Group, the County Health Department and other local health authorities in the catchment areas. Liaison meeting are

attended by medical officers of health, senior health officers and medical and administrative officers of the Hospital Group and Regional Hospital Board. The medical officers of health are represented by their inclusion in membership of the Hospital Management Committee and the Medical Superintendent of the Hospital Group, a Consultant Psychiatrist, serves as a member of the Devon Adult Health Sub-Committee. Weekly case conferences are held at which the Hospital staff meet mental health, probation and other officers for discussion of difficult cases and the most suitable form of care or treatment for particular patients. From time to time local authority social workers accompany the Hospital consultants when making domiciliary visits, and the after-care, which is so essential in making the discharged patient socially viable, is undertaken by the County mental health officers directed by the Senior Medical Officer for Adult Health.

"The maintenance of close and friendly contacts between the Royal Western Counties Hospital Group and the County Health Department continue to be of considerable value."

Care of the Mentally Subnormal in the Community

The social workers in mental health are responsible for the care of all mentally subnormal adults in the community. Assessment panels are held at which those cases of young subnormal persons who have been discharged from special schools or junior training centres are discussed with a view to arranging for future care and training as soon as possible. Medical officers, social workers, school teachers, educational psychologists, youth employment officers and workers from other agencies are invited to these panels to decide what is best in the interests of the individual. Apart from employment the Ministry of Labour Rehabilitation Units can offer courses where these young people can learn a basic trade, or we can offer our own training centres or domiciliary occupational therapy outwork.

Subnormal School-leavers

	1962	1963	1964	1965	1966
Number of special school and junior training centre leavers placed under community care	31	42	59	30	42
Number of children classified as educationally subnormal leaving secondary modern schools and placed under community care	30	34	46	20	27
Totals	61	76	105	50	69

Mentally Subnormal Adults

	1962	1963	1964	1965	1966
Discharged from hospital to community care	72	67	38	89	11
Guardianship cases	2	1	1	1	1
Discharged from community care ..	63	39	65	76	103
Total visits by social workers	3,864	4,178	4,232	4,562	4,134
Total active case load	849	927	909	922	851

Hospital Admissions and Discharges of the Mentally Subnormal

Mental Health Act 1959	R.W.C. Hospital	Special Hospitals	Out-County Hospitals	1962	1963	1964	1965	1966
Admissions: Informal Patients (Sect. 5)	18	0	1	82	54	48	25	19
Observation (Sect. 25)	1	0	0	0	1	0	1	1
Treatment (Sect. 26)	0	0	0	6	4	2	0	0
Emergeneies (Sect. 29)	0	0	0	0	0	0	2	0
Courts (Sect. 60)	7	0	0	4	11	9	8	7
Total admissions	26	0	1	92	70	59	36	26
Total Discharges				*60	*41	*55	*46	*16
Temporary hospital admissions (not exeeeding two months)				25	29	27	19	9
Visits by social workers in respect of admissions				203	124	141	130	108

* Includes 18 (1962), 11 (1963), 10 (1964), 12 (1965) and 5 (1966) persons technieally discharged but remaining resident informally in hospital.

Hospital Waiting List

	Boys	Girls	Men	Women	Total
1962	4	3	9	3	19
1963	12	7	11	3	33
1964	14	9	10	4	37
1965	18	12	14	5	49
1966	17	11	16	5	49

ADULT TRAINING CENTRES

Generally the year has been one of consolidation and progress. There are still nine adult training centres in the County, only two of which (Tavistock and Kingsbridge) are not open five days a week. In August it was possible to move the Newton Abbot Centre to more commodious, although still hired, premises in Kingsteignton and it now operates on five days a week. During the year further education and social training units were established in the newly-built premises at Hawley, Barnstaple.

Two new industrial processes—moulding dolls and toys in latex and the making of gift boxes covered in fancy paper and with glass clear acetate lids—were introduced during the year. This continues the policy of introducing new

materials into the training centres as and when it becomes appropriate so that there is a continuation of work as the more traditional materials fall into disuse.

Five hundred and twenty handicapped persons attended the centres regularly during the year and the total income from the sale of products was £39,023.

East Devon Group (Exmouth, Colyton, Crediton)

The new Doyle Centre at Exmouth was occupied during December and thanks to the planning and hard work of the staff and trainees the move was made very smoothly with very little disruption of the work of the centre. This move has relieved the pressure on the Crediton Centre with regard to the development of "disposables". In addition to the caps, gowns etc., disposable pillow cases are now being manufactured in paper. The Colyton centre continues to function in the Church Hall and in spite of difficulties it is being well supplied with suitable work.

Paignton (Hollacombe)

Latex moulding has been introduced here to supplement the work in polystyrene. Lack of space continues to be a handicap but plans are well advanced to buid the extension. Work should commence early next year to extend this centre for 120 trainees.

Kingsteignton

The two-day-a-week centre at Newton Abbot was transferred to St. Columbas Church Hall, Kingsteignton in August and is now open on five days a week. These premises are hired during the daytime only but fortunately one room is entirely at our disposal so that permanent fixed machinery can be installed there. The making of gift boxes with acetate lids is being developed here and this again illustrates the value of imaginative staff, capable of improvising. Instead of purchasing equipment which could have cost some £1,500–£2,000 the staff adapted existing machinery and had small tools made to their design for less than £100. It will be necessary to obtain the better equipment when the project is fully established in order to meet increased output requirements but the project can still be developed relatively cheaply.

Barnstaple (Hawley)

A full year's working in a purpose-built centre has shown the value of such buildings. The trainees have better facilities and the further education and training unit has had a marked effect on the social behaviour of trainees. A special care unit for the very low grade subnormal has also been established here and has been effective. In the case of one trainee who had been contained in the junior training centre only with the greatest difficulty, his introduction to the training unit and workshop sections of the adult training centre was at first disastrous. After some weeks in the special care unit his behaviour improved beyond recognition and he is now able to enter the workshop section in the afternoons and perform simple tasks although still needing close supervision. The undoubted benefits of such buildings as Hawley cannot be easily measured but we can of course ascertain the income from sales. The income for 1965 when this centre operated in two separate premises was £9,760: in 1966 the income was £18,750 with no appreciable increase in the number of trainees attending.

West Devon Group (Kingsbridge, Plympton, Tavistock)

There was little change in the operation of these centres during the year. The local Society for Mentally Handicapped Children offered the Tavistock Centre the use of a minibus, the money for which had been raised by the Tavistock Round Table. Plans for building a new centre at Tavistock are well advanced and building should start early next year.

Sheltered Workshop (Oakleigh Road, Barnstaple)

This workshop, approved by the Ministry of Labour, commenced in November with twelve approved workers. It appears to be reasonably successful although borrowed machinery is being used, and this severely limits the type of work which can be carried out. The proper machinery will be delivered early next year when projects such as the making of packing cases, toys, furniture, etc., will be carried out.

Dental Inspection and Treatment of Trainees attending Adult Training Centres

This scheme was initiated in 1965. Further progress has been made and the treatments carried out are as follows:

	1965	1966
Number examined	177	167
Number needing treatment	110	88
Number treated	104	70
Number made dentally fit	52	59
Attendance	192	158
Scaling and/or gum treatment	50	60
Fillings	165	183
Crowns, Inlays	5	2
Extractions	143	31
General Anaesthetics	9	1
Local Anaesthetics	83	45
Dentures	19	11
Radiographs	9	4

Many of the trainees are already under treatment in the general dental service. It is not possible, therefore, to inspect every one. All are first invited to attend for inspection and about half accept. These are examined and treatment is offered to those found to need it.

During the year three additional patients were referred for in-patient treatment in hospital. Six fillings and twenty extractions were done for them.

Training for Supervisors of Adult Training Centres

There is establishment for two trainee supervisors in the County, who are attached to various training centres and other departmental services for training. Eventually they will be sent on a full-time course leading to qualification as adult training centre supervisors. Two supervisors have returned from a course at Hull having obtained their qualification and one went to a course at Durham.

Some of the staff have been deferred from these courses by their domestic commitments. To meet their needs consideration was given to a local course run in the evenings. With the co-operation of the Exeter Technical College a course was devised and grafted on to an existing evening course, that of the City and Guilds Technical Teachers' Certificate No. 163. This is run on two

evenings a week over one year and those successful at the examination will obtain a Technical Teacher's Certificate. Fourteen staff are attending this course and if it proves successful another will be held next year.

Therapeutic Social Clubs

The therapeutic social clubs in Devon continue to flourish. At each club a committee, including patients, is formed and, guided by the social workers, decides the club's affairs and manages all financial arrangements. The clubs meet one evening each week and various forms of entertainment are arranged. The social workers in attendance are able to offer advice and guidance to those members who require it, and other helpers include occupational therapists, health visitors and home help organisers.

The Barnstaple Club, known as the Stepping Stones Club, now takes advantage of the accommodation afforded by the new Hawley Adult Training Centre, where they hold their meetings from 7.30 to 9.30 p.m.

Club activities are as varied as possible, and include social evenings, indoor games, groups of entertainers, film shows and talks. In addition, several members still undertake some form of handicraft at home, the materials being supplied at cost price through the department.

The Bideford Club, known as the Torridge Friendship Club, continues to hold meetings at the local Moose Hall and has a very active committee. The social workers in mental health who founded the Club are at present away on courses and those officers temporarily working in this area have very successfully carried on their colleagues' good work. A social worker is normally available at the meetings, but members themselves organise and arrange the activities. The Women's Voluntary Service and British Red Cross Society continue to support the Club by offering transport facilities.

The Paignton Social Club which is held at Midvale Road Clinic continues to be most successful, as does the Torquay Social Club held at Owendene, Albert Road, from 7–9 p.m. Entertainment at both these clubs varies. They are very well attended and the members arrange a varied programme. An annual outing and New Year's supper party and Christmas dinner and dance were very successful.

People who suffer mental breakdown tend to become over-preoccupied with themselves and their symptoms, and because of this many of them experience difficulty in meeting and mixing with others. Besides giving members the opportunity to mix and meet in sheltered environment the club stresses the value of an "outward" interest in life. This manifests itself in the coach and theatre outings—"helping others" and the insistence that members run the club themselves. The Torquay club has a very active and efficient members' committee.

In assessing priorities, account has had to be taken of the needs of about a hundred people returned to the community during the past two years who had spent an average of over twenty years in Exe Vale Hospital. The present day world for these people is very bewildering and they need special assistance in adjusting to it. The social club has proved helpful in this respect but the club's age structure has changed so that it has now taken on the appearance of an old people's club and this has discouraged the attendance of younger persons. The answer is a club for the younger age group but the social workers' duties are too extended at present to organise another club.

Group Meeting

A group commenced in March 1965 on an experimental basis, and continues to meet. Originally described as providing "group therapy", in fact the meetings provide social support, and group therapy within the full meaning of this term is not attempted. For this reason the more appropriate term "group meeting" is now used. Since commencement three separate groups have been formed. The life of each group has been approximately nine months although some members have at their own request continued for longer periods.

The group functions under the aegis of the Exe Vale Consultant Psychiatrists and provides supportive treatment for patients attending their Torbay Outpatient Clinics. Twenty-one members have been referred since the commencing date.

The meetings are mainly for people diagnosed as suffering from neurosis. In general, they are people who seem to have an urgent need to talk about their problems but whose normal life rarely gives them an opportunity to do so. This is possibly due to the fact that whereas physical illness generally engenders sympathy and understanding, mental illness and neurosis in particular quite often evoke disapproval, antipathy and unrealistic advice. Group meetings over a long period provide a suitable and sympathetic environment which allows members discussion of their problems at length. Comments, advice and criticism coming from other group members are often more acceptable and effective than from parents, relatives and/or other people closely involved in the members' lives.

So far the average age of those attending the Group is about 25 years. The marital partners of three members have attended also. This has proved helpful since in each case it has emerged that they were able to discuss problems within the group which for some reason they could not discuss at home without quarrelling. Two who attended for a long period were no better at the end than when they started. Both were totally pre-occupied with their symptoms and wished only to talk about them to the exclusion of any other form of discussion. Nothing dramatic happened when they left the group. Both have failed to respond to many years of differing forms of psychiatric treatment—partly because of their unwillingness or inability to fully co-operate.

Tavistock Club

Following a discussion at Tavistock between various people, the first preliminary meeting of a youth club for the handicapped was held at the Congregational Club Room on 16th November. This meeting was supervised by the social workers together with the area youth organiser and is intended to be a project of service and greater understanding by the normal youth to the handicapped youth of the area, and it is hoped that early in 1967 weekly meetings of this club will be held in the new youth centre to be opened in Tavistock.

HOSTELS FOR ADULT SUBNORMAL PERSONS

There are two hostels for adult subnormals. The first was Occombe House at Paignton: the second at Hawley, Barnstaple.

Each hostel has a House Committee of local district and county councillors who work with the staff and local voluntary organisations for the wellbeing of the residents. They are able to make recommendations to the Health Committee with regard to running and equipping the hostels. We are most fortunate in having several voluntary organisations and societies interested in the two

hostels and much is done to help the residents, both in a financial and practical way especially during holiday times.

All residents at the hostels reeeive 16/– from their soeial seeurity allowance, together with a small wage for either working in the hostel or at an adjaeent adult training centre. On admission to a hostel the residents open a Post Office savings account and are encouraged to save for holidays and personal effects.

Occombe House

This hostel which has eleven female and twelve male residents was opened on 23rd Oetober, 1965 and has proved to be most satisfaetory. It is staffed by a warden and matron; deputy matron; resident cook and gardener/handyman who works on a daily basis. The deputy matron lives in only when required on normal duty.

During the year ten female and six male residents were admitted—five from parents' homes; three from relatives; four from lodgings and four from normal homes on a short-term basis. Fourteen residents were discharged—seven males and seven females—two at parents' request; two at own request; two to residential employment; three because they were unsuitable at the hostel; four who were on temporary short stay and one transferred to the new Hawley Hostel. Three were working in full-time employment.

At weekends nearly all the residents visit Paignton, Torquay or Brixham for loeal entertainment. On Tuesday evenings many attend the leisure club at Hollacombe Adult Training Centre and on alternate Mondays there is a social evening at Paignton organised by the Torbay Society for the Mentally Handicapped. During the year thirteen residents spent a holiday with relations or friends for at least a week, two of them visited the Westward Ho! Holiday Camp for the Handicapped.

Hawley, Barnstaple

This hostel was eompleted during the year and admitted residents on 6th June. It is staffed by a matron and warden; assistant matron and warden; daily cook and assistant cook. The hostel is attached to a 120-plaee adult training centre by a kitehen which serves both establishments. The matron and warden are responsible for the kitchen and in preparing meals not only for the residents of the hostel but also the training centre and the local "meals on wheels" service. The accommodation available is for twenty-seven adults—nineteen males live in the main building and eight females are aecommodated in an annexe some thirty yards from the main building. The assistant matron and warden sleep in a small flat in the annexe and have a sitting room in the main building. Seven patients were admitted from hospital; fifteen from their homes and five from other residentaial establishments. At present there is one person in full-time employment and other residents either work in the hostel or attend the adult training centre. All residents are taken out by the staff at weekends and holidays, and for this purpose the training eentre minibus is used.

The following is an artiele published by "The British Hospital & Social Service Journal" as the result of a survey made by two members of my staff and I think it makes interesting and informative reading:

EXPERIENCE WITH A HOSTEL FOR SUBNORMAL ADULTS

A. Lyth (*Warden, Adult Hostel*)
J. Corpe, *C.S.W.* (*Social Worker*)

Residential hostels for the mentally subnormal are rapidly becoming part of community psychiatric social services throughout the country. This article seeks to give administrators and social workers useful information about the hostels and the people who live in them.

Experience indicates that hostels accommodating between 20 and 25 residents are perhaps the best size. Larger hostels need more staff and as a result much of the home atmosphere is lost. Smaller hostels, however, usually do not have sufficient staff to operate a duty rota system. In this case the warden and matron often work alternate duty thus leading separate lives—or they work together as a team and seem to be forever on duty.

Hostels are well sited in residential areas, but thought must be given to local residents. At an early stage efforts should be made to meet them and discuss the hostel and its residents in an endeavour to allay any fears or suspicions. Residents should be encouraged to meet local people, shopkeepers, etc., —attendance at the local church is helpful in enabling residents to mix and meet with local people.

Criteria for admission to a hostel should depend on its particular terms of reference. When a hostel is supposed to cater especially and only for adult subnormal persons, then no pressure or influence should be used to admit other than this category. Accommodation is scarce in hospitals catering for subnormal and severely subnormal persons. As a result many clients in the community are unable to be admitted to hospital although their condition and circumstances are often most distressing and their need for admission palpably clear and urgent. In this situation when a hostel has a vacancy extreme pressure is sometimes used to get it allocated to a client in the community who really needs care and treatment in a hospital. Staff and residents alike suffer when clients are admitted to a hostel which lacks the facilities to cater for them and their particular needs.

In general, residents admitted from psychiatric hospitals seem to adjust to hostel life more easily than residents admitted from the community. This perhaps is understandable since they are already trained in matters of personal hygiene, money, care of clothes, etc., and additionally most of them have previous experience of adjusting to a new and perhaps strange environment. Care should, nevertheless, be used in accepting residents from psychiatric hospitals since whilst they may seem well behaved and well adjusted in hospital, they sometimes change completely when they leave. Initially therefore, it is prudent to accept such residents for a trial period only, during which time it is understood they can be returned to hospital if their behaviour or condition deteriorates. This is necessary because experience indicates that once a patient is officially discharged from hospital their bed is allocated to someone else and it then becomes almost impossible to arrange their re-admission.

When residents go on holiday either to their families or elsewhere it is helpful if their bed can be made available for "short stay" purposes. This enables selected clients in the community to have a holiday from their families and/or gives the families a little relief from the problem of caring for them.

Staff should seek to be neither too authoritarian nor too permissive. They should at all times present themselves as professionally helpful persons and avoid adopting parental attitudes; bearing in mind the resident's need to retain his loyalties to his real parents and the parents' need to feel that they have not

lost their son or daughter. Staff should seek to achieve the same relationship with all residents; obviously they will have their favourites but they should try to ensure that residents are unaware of this. When it is obvious that staff have favourites, then the residents become confused and sometimes very unhappy; cliques form and jealousy is aroused.

With hostels sited in large towns or cities, social workers who admit residents will probably be responsible for future support. In the case of hostels sited in county council areas, however, some residents will be admitted from homes a long distance away and the social worker who arranged the admission may not be operating in the immediate area of the hostel. When this happens it is perhaps best for the local social worker to be responsible for routine visits and any minor local problems which may arise. Prime responsibility, however, should remain with the social worker previously responsible. He should continue visiting the resident's family and also the resident, as frequently as distance and work pressures allow. Many relatives are unable to visit because of their age or the long distance involved and sometimes for financial reasons. In these cases social workers provide an important service in not allowing either the resident or his family to feel or become isolated from each other. Residents who do feel isolated from their families often tend to become depressed and/or their behaviour deteriorates.

Problems arising from accommodating both sexes in a hostel are not as frequent or difficult as might be expected. Initially there may be shyness or petty jealousy. After a short time, however, shyness is overcome and jealousy diminishes. Occasionally residents "pair off" but reasonable supervision and firmness minimises the chance of misbehaviour. When this does occur within the hostel it is reasonable to suppose it would have occurred outside the hostel and the episode should not be overdramatized. Experience indicates that there is a greater chance of misbehaviour between a resident and a local man or woman meeting outside the hostel. Therefore, the most vulnerable residents should be discouraged from going out alone. The advantages of having a mixed hostel, however, seem to outweigh the disadvantages. Residents seem to be at ease and not embarrassed in mixed company: this helps in their adjustment to a new and different environment.

Older residents tend to become tired of high spirited younger residents but this is perhaps normal in any community situation. Care should be taken in selecting residents to share bedrooms. In general, similar age groups should be kept together, with older residents being given priority for single bedrooms. There are disadvantages in having multi-bedrooms but these are, perhaps, outweighed by the advantage of residents learning to help each other which is important during the initial period of loneliness and change of environment.

Although hostels become permanent homes for most residents, return to normal community life is possible in some cases and this fact should always be at the forefront of the minds of both hostel staff and field social workers.

Many able-bodied, high grade subnormal residents are admitted from previously over-protected sheltered home environments where all their daily needs were catered for by others and where the question of employment never arose. Whatever their previous work record, however, all residents should be encouraged to undertake employment as a first step towards rehabilitation.

Most residents will attend a local authority training centre. Here, and also in the hostel, many learn to become potentially useful employees who can be placed in normal employment. For obvious reasons residential employment is the most convenient. Residents who progress sufficiently to undertake normal

employment, however, can often be found good lodgings near their work. This type of rehabilitation, besides giving residents the opportunity to lead more normal and useful lives in the community, additionally creates vacancies and thus makes the hostel a "continuing" rather than a "blocked" facility. Residents who do leave to live and work in the community should be encouraged to maintain contact with the hostel and its staff. Weekend visits, and even holidays at the hostel, are helpful in giving ex-residents the feeling of having "family background and support".

Residents undertaking normal work in the community may have difficulty in understanding their financial position. In particular, they often cannot see why they should pay towards their maintenance while other residents do not pay, and additionally they are given pocket money. Reasons should be carefully explained to them in simple terms, and in such a way as to make them feel some pride, but no arrogance, about the fact that they are supporting themselves.

Residents who work at the hostel as domestics should be paid as "outworkers" from the industrial workshops. This ensures that all residents working in sheltered employment receive the same financial reward and no one feels at a disadvantage. Usefulness as a somestic should not tie the resident to the hostel and perhaps a hostel domestic duty rota is the best and fairest system with regards this type of work.

Finally, relatives should be encouraged to visit but discouraged from making a nuisance of themselves. This sometimes happens with over-protective parents who try to lay down special rules and conditions for the care and treatment of their resident son or daughter. Residents and other relatives are quick to notice when someone is receiving preferential treatment and this is always upsetting for them. Relatives who travel a long way to visit the hostel should be made especially welcome and if necessary arrangements should be made for them to have a meal at the hostel. In some cases it may even be necessary for the social worker to arrange overnight accommodation, but in any case no trouble should be spared in helping relatives, whose circumstances make it difficult for them to visit.

OCCUPATIONAL THERAPY

Staffing

The establishment for the year was for twenty-three occupational therapists and three vacancies remain unfilled at 31st December. This means that the Torbay and Exmouth areas are under-manned. When it seemed unlikely that all posts would be filled, two technicians were appointed in place of therapists.

The principle of appointing part-time staff was also adopted and this has proved very satisfactory. These members of staff have returned to the profession with a real will to work. They have proved mature in their approach to work and planning, and have been extremely conscientious.

Technicians work with the occupational therapists in the assessment and training of those less able both physically and mentally. They also supply a much needed male influence in this section. Whilst assisting in the unit the technicians undertake the manufacture of custom-made aids and gadgets for individuals. Previously, the client went without these or had to wait a very long time for them. The technician works to the therapist's specifications, and also accompanies the occupational therapist to the client's home to give advice and to fix the required aid. It is often difficult to get a builder to do small jobs quickly and by using technicians the patients' needs are more quickly met. The following

aids—unobtainable elsewhere—have been produced: purpose designed walking aids for handicapped pre-school or infant school children; safety bath aid for a retarded, blind, epileptic boy; an appliance to lift a patient from lying position to standing to relieve his elderly and disabled mother; special adaptations to chairs for both adults and children and an outsize commode for a very large, elderly lady. The technicians' help is more than filling the gap in the service and the therapists are most appreciative.

Domiciliary Service

The County's therapy service has continued to be in great demand and there are some 1,600 cases on the register at 31st December. Aids to daily living and advice on structural alterations take up the greater part of the therapists' time and is most rewarding. It is essential that clients are taught to use the aids supplied correctly and with confidence. The therapists pay regular check visits to all clients with aids and supervise their continued maintenance. The therapists continue to visit patients with aids issued by hospitals and voluntary associations—some of these many years ago. Due to wear and tear these aids may have become dangerous. A worn rubber on a stick or crutch can let down the owner who may treat it with complete confidence. Similarly, aids issued in a hospital or clinic may not be suitable for the home. A tripod may fill the need in a physiotherapy department where the floor is level, but it could be a menace on an uneven tiled floor or a broken surfaced path.

It would appear there are many elderly and severely handicapped persons at home who are not functioning as well as they might. Bed-lying and invalidism are still accepted as logical and legitimate—often when the degree of disability does not warrant this. The factors governing such an attitude are:

1. The visits of the therapist are looked on by the patients, the doctor and the therapist as being palliative rather than definite and prescribed treatment;
2. Relatives are often unprepared to give time and trouble to patients to teach them to help themselves and find it easier to do things for them. Later when through frustration the patient becomes either a parasite or a tyrant, relatives cannot see that they are largely to blame;
3. The desire of social and medical workers to give the patient props—often necessarily—and to relieve him of any duty or action that is difficult or unpleasant. There appears to a great urge on the part of the field workers and therapists to do something concrete—to be kind to the patient rather than undertake the more unrewarding task of re-educating him;
4. The difficulties of an individual locality—often lack of help to get a patient in and out of bed means that he remains in bed all day. There is a great need for a more co-ordinated and intensive care in the early stages of the handicap to ensure that patient and family fully realise how much each can contribute to the home community.

It is impossible to enumerate the activities undertaken and encouraged by the therapist to relieve boredom, and craft work still plays a large part in this. With the apparent increase in the cases of multiple sclerosis and allied diseases there is a need to plan early for activities which will not be a cause of frustration as manual dexterity decreases. With this in mind the therapists are trying by various means to build up a stock of tape recorders and typewriters. Through this media patients can express themselves and communicate with other persons outside the home. These patients are often highly intelligent and not only can they themselves find outlet in using a typewriter but can help other patients in the early stages of their difficulties by discussing their problems.

In the Dawlish area an electric typewriter is on loan for short periods to a group of such cases and it is passed from one to the other. It is hoped that they will all contribute to a news letter. A similar machine in North Devon has been adapted with a perspex shield to obviate patients with intention tremor or diplopia tapping the wrong keys. Another activity being explored is amateur radio. Here local societies will adopt patients and give much advice and financial aid.

The gap made by the closure of the Red Cross library service has been more than adequately filled by the County Library who have made available a box of about twenty books at a time for each therapist needing them. Often the home-bound person has to rely for his books on relatives or neighbours whose tastes are not the same as his. This means extra work for them and the patient feels that it is an imposition and therefore is unable to ask for help and gives up reading. The therapist studies the client's tastes and is often able to guide him to a wider and more satisfying selection of books. It is of interest to note that many patients have remarked on the apparent newness of the books supplied by the library. Well protected and with bright dust covers they have made a great impact and the patient does not feel so cut off as he did when he received well-maintained but obviously second-hand books. The therapists are very grateful to the County Librarian and his staff for their willing and sympathetic help.

There has been an increase in the number of school and pre-school children who have been referred. Too often in the past these cases have only come to the therapist's notice when there was a major problem. This year a young boy of sixteen years was referred to the service. He had been virtually home bound all his life and had become a real tyrant, bullying his mother and demanding all her attention and energy. He had been provided with daily schooling, but after school closed, the remainder of his day had been unoccupied. The therapist feels that had she been called in earlier then she could have helped the boy to lead a fuller and happier life and also have helped the mother with various aids.

It is essential to start training the handicapped as early as possible as they will have to work far harder to achieve the same results as their contemporaries and the relatives must be given adequate aids to relieve all physical difficulties. They will need every ounce of energy to encourage help and guide the patient.

Patients receiving domiciliary occupational therapy in 1966

	Boys	Girls	Men	Women
Physically disabled	12	5	518	866
Mentally Ill	—	—	43	28
,, Subnormal	10	8	49	79
Severely Mentally Subnormal	3	—	—	1
Total	25	13	610	974

Rehabilitation Training Units

Except for the unit at Hawley there has been very little progress in this section during the year due both to lack of space and lack of staff. This is to be regretted as the adult training centre and the rehabilitation unit should develop together.

At Colyton, an occupational therapist attends one day a week but can provide only very limited activities owing to a total lack of facilities.

At Kingsteignton and Hollacombe there has been no space available fo form a unit. At Plympton, although the three therapists each attend one day a week the facilities were so poor and the space so urgently needed for work projects that the attempt to set up a proper unit proved abortive. At Tavistock the therapists are now able to give three full days a week and a new effort is being made to provide unit activities, but here again facilities are limited. The unit at Crediton has been able to return to five days a week. There are more facilities here, but the space is very limited—the unit being sandwiched between the kitchen and the workshop with their noise and traffic does not provide ideal conditions.

At Exmouth the unit continued to operate on only two days a week at All Saints Church Hall and will continue to do so now that the centre has moved to new premises until a full-time occupational therapist is appointed.

At Hawley the training unit operates five days a week and has splendid facilities. A wide range of activities has been organised. Until November when a technician was appointed the occupational therapist worked single handed and owing to the shortage of supervisors in the workshop often had more trainees than planned and thus could not give the individual attention required. There is excellent liaison between the unit and hostel and when girls have been brought to a fair standard of reliability in domestic work the matron accepts them to work in the hostel where the routine is more like that of a small guest house and where they are subjected to greater work pressures.

All new trainees now pass through the unit for assessment. Much of the work here is experimental regarding methods and activities and calls for continued re-appraisal. The staff are constantly bringing forward new projects for discussion and are most enthusiastic. They are prepared to go to great lengths to help obtain equipment for their trainees—some of this from voluntary sources.

A system of work projects has been started. These are mainly to improve the present unit and provide training points. Each trainee is integrated into the team and his part in it is recorded. This increases enthusiasm and improves inter-trainee relationships and engenders pride. The project in hand at the moment is a partition to screen the bedroom area from the rest of the training unit.

Therapeutic Clubs

There is a need for creative and satisfying activities for the elderly. This has always been apparent and will increase. Although there are social clubs, rest rooms, etc., there are still some people who cannot be accepted into them, either because of being very severely handicapped or because of an awkward personality. Such groups must necessarily be small and be organised by a person trained to accept the fact that these people need help and are not merely setting out to be awkward.

A pioneer group has been set up at the unit at Hawley each Tuesday afternoon and is run by two occupational therapists in rota. It is run on club lines and the participants are encouraged to take as much responsibility as possible. Besides arranging craft and remedial activities they undertake recreational and intellectual sessions and are encouraged to organise their own activities. About twenty people from the area attend according to their needs—some each week and some fortnightly. The relatives also benefit by having a periodic afternoon free. On return home the club member has new things to talk and think about. The therapist's work load is also relieved by seeing a number of

her cases at this group, therefore cutting down on home visits. Work can also be provided at the club for members to take home. This is often a group project for some charity.

Pre-School Handicapped Group

This small group was instigated by a medical officer who felt there was a need to help both parents and child at an early age. The actual organisation of voluntary helpers, transport, etc., is carried out by a member of both the Handicapped Association of North Devon and this pre-school group. The occupational therapists give advice and control the activities.

So far eleven children have attended. The group caters for a great range of disabilities. The aim of the group is to prepare the child and make him acceptable for school by the time he should attend, and also to provide help to the parents. The parents are encouraged to bring their children to the centre themselves and either to remain and discuss them and help with them, or else to go off in a group and have tea and discuss their problems amongst themselves. During the afternoon the children are helped to undertake activities such as block building, crayon work, climbing and any activity to help towards the progressive development of co-ordination, musculature and communication. The children have afternoon tea (or milk), and biscuits. This teaches the children manners and tolerance and also how to behave in a group. After tea the child is allowed to move and play freely.

When this group started all the children were completely isolated. Six were non-communicative, and two unable to walk. Now, although three are still non-communicative, the others are walking and making known their wants and within the last few weeks are beginning to fit into small groups. One child was excluded from the nearby junior training centre as she was heavily handicapped and a danger to small children. The group has been able to contain her and the other children have learned to show her toleration and exercise a degree of self-preservation when she is near. A record player is being provided and this will be a great asset. The centre operates each Monday and Thursday afternoon.

Outwork

The provision of paid outwork for the home bound has proved extremely difficult. Those living within easy reach of the training centre are fairly well served and can earn a reasonable amount, but those living at a distance lose out because of the delay in the return of the work.

The spasmodic flow of work is also a great problem and a cause of frustration. The therapists are sometimes criticised for not filling the gaps with craft work but after years of struggle to wipe out the "Wool Lady" image this is perhaps forgiveable: in fact the preparation and finishing of craft work takes up much of the therapist's time. One can only hope that there will be an increase in sub-contract work so that those who are debarred from the amenities of an adult training centre by greater disability or lack of transport will receive more help.

Shortage of Occupational Therapists

The therapists have done much during the past year to further both the education of therapists in training and to recruit school leavers to take up the profession. About fifty young people have been given a chance to see therapists

at work and information has been given to careers teachers and conventions. Until the transfer to the Doyle Adult Training Centre three therapy students from St. Loyes went each week to help with the social club.

The film strip "Towards a Fuller Life" about domiciliary occupational therapy which was made by the Health Department has proved a great success both here and abroad and was shown to the Fourth World Conference of Occupational Therapists when the Duchess of Gloucester was present. Although scheduled for one showing it was repeatedly asked for at this conference. The film strip has been continually in use during the year for showing to various groups.

THE CHIROPODY SERVICE

This service continued to grow during the past year. It is available for the elderly, the handicapped, expectant mothers and schoolchildren. No charge is made to those in receipt of National Assistance and schoolchildren, but for all others the charge is 2/6d. per treatment and 4/– for a domiciliary visit. During the year six chiropodists were appointed and two resigned, bringing the total number employed to eighteen full-time senior chiropodists in addition to the chief chiropodist. Thirteen new clinics were opened, making the total number in the county one hundred and thirty-four. The waiting lists at the various clinics continue to rise and because of this it has not been possible to extend the domiciliary service which continues only in a very limited way in the Torquay/Paignton and Tavistock areas.

The main object of this service is to keep elderly people mobile and fit enough to reside in their own homes, instead of allowing them to become housebound and eventually need residential care. The hospital car service continues to offer transport to the clinics for those patients medically recommended. In many instances this service is only needed for initial treatment and these patients are then able to make their own way for further treatments. The chief chiropodist continues to work in clinics in the area around Exeter, and the staff of senior chiropodists are based at each of the following towns:
Barnstaple, Bideford, Brixham, Exeter, Exmouth, Honiton, Ilfracombe, Kingsbridge, Newton Abbot, Okehampton, Paignton, Plympton, Plymstock, Sidmouth, Tiverton, Torquay and Totnes.

Treatment to Schoolchildren

The chiropody service at the moment is normally available only to children in the Torbay area, where one whole day each week is allocated for this purpose.

During the early part of November a school medical officer requested urgent help with treatment for an outbreak of verrucas at a county secondary school in East Devon. Forty-five pupils were reported to be infected. At an examination of all third-year pupils sixteen were said to be under treatment from the various general practitioners. Thirty commenced weekly treatment under the County service and these cases were cleared in three to four weeks. As a result of this the medical officer contacted general practititoners in the area and asked if they wished the remaining cases to be dealt with bythe County service. All general practitioners agreed.

Appliances

Because of the number of people awaiting chiropody treatment appliance-making has been kept to a minimum, but it is hoped in future to do more of this work.

Voluntary Organisation

The British Red Cross Society continues to operate one chiropody clinic at Chulmleigh and receives an annual grant from the County Council for this purpose.

County Chiropody Clinics

	1962	1963	1964	1965	1966
Number of chiropody clinics operating ..	52	63	96	126	134
Old Peoples Homes visited (Welfare and Private)	4	9	15	21	28
Treatments at Welfare Homes	229	397	888	1851	2615
Treatments at Private Homes	212	101	200	737	611
Treatments to school children	0	363	1542	916	1136
Treatments to adults at clinics	9599	17270	26530	38550	43824
Domiciliary visits to give treatment	0	0	329	737	950
Total treatments provided	10040	18131	29289	41317	49136
Waiting List at 31st December	151	432	498	762	482

Hospital Car journeys undertaken—5,771.

RETIREMENT CLINICS

In the country as a whole the problems of the elderly are becoming more numerous. In Devon, however, where the proportion of the population over 65 years of age is almost double that in the rest of the country, it is particularly important to improve services for retired people.

A great deal of physical, mental and social ill-health amongst the elderly can be prevented, or treated when it is still at an early stage. In order to do this it was decided to set up special clinics which we agreed to call retirement clinics. Our problem was to decide upon the most suitable form for them to take.

We consulted other authorities who already had geriatric clinics and we had meetings to discuss the problem with people in Devon with special knowledge of the health of the elderly. A great deal of useful information was obtained in this way.

It soon became clear that if we were to get a high acceptance rate from the retired population, and if the interests of the patients were to be best served, it was essential that each patient should be seen by his own general practitioner. A general practitioner with an age/sex register knows which of his patients are in a particular age group so it is possible for him to invite them to attend.

A pilot study was started at Paignton early in the year. This is described in more detail later. From this Paignton Survey we have been able to obtain more precise information on the most suitable scheme for our clinics.

We decided that each patient should be invited to attend by his own general practitioner. If he accepted, he would be given a questionnaire to complete, and given appointments to attend for examination on two occasions. At the first visit he would be seen by a health visitor who would be able to help with any social problems, and also by local authority clinic nurses who would do screening tests. Later, when the results of all the tests were available the

patient would be examined by his own general practitioner. The general practitioner would be paid a sessional fee by Devon County Council for this work. If any abnormality was found the general practitioner would then be able to follow it up in his own time in the way he felt most suitable.

Thus, by the end of the year, a definite plan had been evolved, several general practitioners had agreed to take part and money had been allocated to enable six retirement clinics to be put into operation by the end of the financial year 1967/68.

As with most schemes money will be a limiting factor. However, with this completely new venture it is probably better to start slowly but in the best possible way. We have every hope of having a high acceptance rate from our patients, of helping our patients to have a healthier and happier retirement, and also by careful planning and recording to produce some useful statistics which will provide information about the health of the elderly which is so far unknown.

THE PAIGNTON SURVEY (Interim Report)

by Dr. J. F. BURDON (General Practitioner)

During the autumn of 1965 it was possible to plan an investigation in a general practice in Paignton to be carried out by a family doctor with the help of the Devon County Council Health Department. The objects of the study were:

1. To guide Devon County Council Health Authority in its planning for retirement clinics so that it might apply its resources efficiently.
2. To discover morbidity previously missed (degree and remediability).
3. To compare diagnostic methods of different kinds and to determine their relative efficiency.
4. To determine norms in the age groups studied under the prevailing conditions of diet and environment.
5. To compare patterns of test results for different diseases.
6. To relate morbidity to environmental factors where possible.

Details of the Groups Studied

All patients who were born during the years 1896, 1901, 1906, 1911 and 1916 were offered participation in turn so that these age groups from 50 to 70 years were covered systematically. This is a random selection of the patients concerned, and the results should be of general application to the population of Devon, at these ages. Factors militating against randomness were that certain patients refused to participate and that the practice chosen had not exactly the same age-sex structure as the County of Devon, though it closely resembled it.

Each patient will be re-examined after five years.

Method

In the first instance a letter from the family doctor on the following lines: was sent to each patient concerned, dealing with them in batches of twelve for convenience and spreading the work over the year,

My dear . . . ,

Doctors have always tried to tackle disease before it takes a firm hold, and one of the ways of doing this is to look for it before symptoms appear. This is the purpose of what the Americans call a "health check-up".

Thanks to the forward-looking policy of the County Health Service I am able to offer a health survey to a selection of my patients, and you are one of those fortunate enough to fall into the right age-group to qualify for this. The whole procedure will be under my supervision and control, and will be available at your home and at my consulting rooms in the ordinary way. No charges will be made. You are of course at liberty to decline this invitation if you wish.

The Health Visitor attached to my practice, Miss A. D. Matthews, will be getting into touch with you shortly to tell you more about the survey, and to initiate the process. It will be rather like a life-assurance examination, though at greater length.

I do hope that you will participate. Apart from the personal benefits which may follow for you, we hope to learn a lot about unsuspected diseases in the community and how to deal with them. My only regret is that I cannot offer participation in this survey to more than a fraction of my patients.

With kind regards,

Yours sincerely,

After this letter had been sent the Health Visitor attached to the practice, Miss A. D. Matthews, went to the home of the patient concerned, answered questions about the survey and encouraged enlistment. Miss Matthews completed a questionnaire detailing particulars of the patient, including place of birth, duration of residence in Paignton, occupation, family history of disease, previous illnesses of importance, nature of diet, smoking habits, exercise taken, hobbies and interests, religion, number of possessions from a specified list, habits as to holidays, knowledge of social services, pets kept, sleeping habits, general level of activity and an assessment of home comforts. She also assessed the degree of loneliness of the patient and made a short general report.

A questionnaire was left for the patient to answer, consisting of simple questions (e.g. "Have you any phlegm?" "Is your appetite poor?") to which a "yes" or "no" answer could be given. This the patient completed and attended by appointment at the doctor's surgery where a nurse, provided by the county, went through the questionnaire to amplify the details given and elaborate the medical history.

The nurse appointed for this task, Mrs. Pearl Young, also emasured and recorded the weight, height, chest measurements, pulse rate, blood pressure, vitalogram, reaction time, tonometry measurements, breath-holding test, hearing, urine tests on two samples (on rising and after supper), visual acuity, colour vision, and she also wrote a short report. Samples of urine taken by nurse were sent to the Public Health Laboratory Service at Exeter, for examination and culture, and samples of blood were obtained and sent to the Laboratories of the Torquay Hospital Management Committee at Torbay Hospital, and to Taunton where the consultants concerned, Dr. Peter Warren (Torbay) and Dr. J. Harkness (Taunton), kindly reported upon the biochemical features of these samples. As the survey proceeded the ankle-reflex time was added.

The documents thus far assembled, nine foolscap pages in all, then passed with the patient to Dr. Dorothy Cullen (D.C.C.) who did a formal medical examination of the patient, recording all the usual things and in addition doing cervical smear tests for all the women.

Finally the patient attended to see his own doctor, who completed the medical examination, including the prostatic examination for men, the electrocardiogram, and psychological tests designed to pick out mental ill health.

The Pilot Study

It was necessary with so elaborate a study, to develop the procedures gradually, For this reason, until it was felt that the procedure was satisfactory, the patients were regarded as being part of a pilot study. By mid-1966, fifty patients had been examined, numerous improvements had been made to the original forms, and it was decided to start the main part of the survey. Dr. J. R. Ashford (Senior Lecturer in Mathematical Statistics, Exeter University) was most helpful in giving advice on layout of forms to be suitable for computer analysis.

The medical participants had the advantage in June 1966 of attending a specially arranged inter-disciplinary conference in Birmingham, organised by the Research Adviser of the College of General Practitioners (Dr. R. J. F. H. Pinsent) and including representatives from the Ministry of Health, the Medical Research Council, the University of Birmingham and the University of Keele amongst others. Several doctors engaged in similar research attended,and a whole day was given to debating the Paignton Survey and related systems of screening for disease. Following this the general practitioner concerned, and Dr. Dorothy Cullen, attended by invitation the Ministry of Health, and spent the best part of an afternoon discussing the Paignton Survey project with Dr. D. H. D. Burbridge and his colleagues at Alexander Fleming House.

The Main Study

Since the main part of the study began methods have been consistent, and an attempt has been made to deal with three patients each week. It has been impossible to increase this rate of flow because of the pressures upon the general practitioner who has had to allot half a day a week to deal with the survey and its consequential labours.

A preliminary review of the results in early March, 1967, when some 54 complete reports in the main study together with the 50 reports from the pilot study were analysed, gave the results below. These findings must be interpreted with caution; it should be remembered that all the patients were middle-aged or elderly and no youngsters were included. The number involved is still too small to warrant much to be deduced, and it will be necessary to continue to collect data for some time if sound and reliable foundations are to be built for worthwhile and reliable conclusions to be reached. All graduations of the diseases named are lumped together, some being minimal discomforts which the patients were ignoring, but which the doctor thought might be treated with benefit. Diagnosis in each case is the most precise that the clinical data allows. The College of General Practitioners' modification of the International Classification of Disease has been used throughout. Each disease episode appears once only in the table.

No. of patients examined—104

Some of the surprises in the above table may have been coincidental, for example the "fractured ribs" was recognised by the patient; the doctor got the impression that the patient knew what had occurred, was not bothered unduly by it, and would not have attended for it in the ordinary way. The newly-found coronary thrombosis was proved by ECG, ESR, LDH and second opinion; there was no pain or discomfort at any stage and the attack had apparently occurred about two weeks before the survey examination. Further ECG's at intervals showed the usual return towards the normal pattern. The presentation set a difficult problem in management for the doctor.

One of the chief fruits of the study so far has been the enhanced perception of the doctor. For example, because wax was found to be so common in general, an aged lady (83 years) no longer had her deafness taken for granted by herself, her relatives and the doctor, and after discovery and removal of wax found that her hearing was greatly improved—it appears that deafness in the aged should never be taken for granted! Again, a study of haemoglobin levels has disclosed that haemoglobin in men is frequently lower than a 'normal' distribution would lead an observer to expect, which implies an unrecognised reservoir of anaemic males, This matter is being further investigated as of special importance.

Several other interesting and possibly important findings, as yet speculative for want of greater numbers, have been uncovered.

One dramatic presentation, not classified in the tables because not completely investigated at the time of writing, was a man whose haemoglobin value was 55 per cent (severe secondary anaemia) though he felt well except for recent mild flatulence.

An urgent barium meal X-ray revealed early and apparently curable cancer of the stomach months before it might otherwise have come to light. He has expressed the hope that he may have the rest of the survey tests after his operation!

As the main part of the study progresses throughout 1967 the age groups will be arranged to include the next years to those completed, so that equal numbers in each group will be examined and the results will be of more general application than is possible at present. It is hoped to continue for several years. While doing this those concerned are keeping in mind three factors which influence the whole project:

1. How common is a disease?
2. How serious is it?
3. How treatable is it?

Each of these questions deserves an answer before the inclusion of a search or disease in a regular, official screening programme can be recommended.

It would be unwise at this stage to attempt to draw conclusions about the health of the age-group that has been studied or the desirability of retirement clinics from these figures alone. The Survey is still in operation and we should await further results.

The difficult question of availability of resources for treatment has been left to the future. It is assumed that the community will wish to provide for any needs which are brought to light by this investigation.

Acknowledgements

The general practitioner concerned, Dr. J. F. Burdon of Paignton, wishes to express his gratitude particularly to the County Medical Officer of Health, Dr. J. Lyons, and to the team which has been attached to and has supported the Paignton Survey, including Dr. Dorothy Cullen, Miss A. D. Matthews, Mrs. P. Young, Dr. Peter Warren, Dr. Harkness, Dr. Brendan Moore, Dr. D. H. D. Burbridge and his colleagues at the Ministry of Health, Dr. J. R. Ashford and Dr. N. G. Pearson (Epidemiologist) at Exeter University, Dr. R. J. F. H. Pinsent and his colleagues, and the technicians who have so generously and readily given their assistance and careful attention to this demanding task. Further reports will follow.

Results to March 6th, inclusive: 50 patients in Pilot Study and 54 in Main Study so far completed:

Age-Sex distribution:

MEN (49)	Age	50	55	60	70	70	WOMEN (55)	Age	50	55	60	65	70
	Total =	4	17	6	10	12		Total =	9	12	5	15	14

	KNOWN BEFORE SURVEY										NEWLY FOUND AND REQUIRING TREATMENT										
	MEN					WOMEN					MEN					WOMEN					
Ages	50	55	60	65	70	50	55	60	65	70	50	55	60	65	70	50	55	60	65	70	Total
Communicable diseases																					
Dermatophytosis									1		1										2
Neoplasms																					
Bronchial carcinoma															1						1
Benign neoplasm (uterus)																			1		1
Benign neoplasm (skin)														1				1	1	1	4
Benign neoplasm (other)												1			1				1	1	4
Enlarged lymph glands															1						1
Allergic, endocrine, metabolic and nutritional																					
Hay fever							1														1
Asthma		1					1				1								1		4
Allergic dermatosis						1															1
Hypothyroidism					1		1										1		1	3	7
Diabetes				2					1	2				1	1						7
Vitamin deficiency												1		1				1			3
Allergy to wasps															1						1
Gout														1							1
Obesity*				2	3	1	2	2	2	4	2	1	4	4	1	1	2	2	1	5	39
Diseases of blood																					
Pernicious anaemia				1																	1
Hypochromic anaemia						1	1		1				2	2	2	1	1			1	12
Psoriatic anaemia		1																			1
Mental and psychosomatic disorders																					
Endogenous depression															1	1	1		1	1	5
Anxiety state			1													2	1		2		6
Reactive depression				1					1				1		1		1		1	2	8
Chronic anxiety with somatic symptoms					1	1		1		2											5
Neurasthenia			1																		1
Low I.Q.															1						1

	KNOWN BEFORE SURVEY										NEWLY FOUND AND REQUIRING TREATMENT										
	MEN					WOMEN					MEN					WOMEN					
Ages	50	55	60	65	70	50	55	60	65	70	50	55	60	65	70	50	55	60	65	70	Total
Nervous system and sense organs																					
Paralysis agitans				1		1														1	3
Epilepsy					1																1
Migraine																		1			1
Paresis of muscles																				1	1
Other diseases of nervous system																				1	1
Refractive errors (untreated)			1	1						1				1			1	1	1		7
Squint																		1			1
Chronic blepharitis									1												1
Cataract							1	1		2				1							5
Early glaucoma										1								2	1	1	5
Other diseases of eves					1				1						2						4
Chronic otitis media		1					1								1						3
Mastoid disease					1																1
Wax needing removal									1			7	2	3	5	3	2		1	2	26
Deafness (not due to wax)				3	1		1		2	5	1	1		1					1	1	17
Otosclerosis										1											1
Circulatory diseases																					
Rheumatic heart diseases							1		2					1			1	1			6
Coronary thrombosis												1									1
Other arteriosclerotic heart disease				1	1							2					1				5
Other types of heart disease				1										1	1						3
Hypertension		1		1	2				1									1	2		8
Chilblains																				1	1
Arteriosclerosis				1						1											2
Varicose veins	1				2	1	3	1	1	4		1	2	1	1	1		1	5	1	26
Haemorrhoids		1							2	1							1			1	6
Other circulatory disease				1													1		1		3
Angina pectoris		3		1			1			1								1			7
Oedema (cause uncertain)							1									1	1				3
Thrombophlebitis		1		1																	2
Respiratory diseases																					
Pneumonitis		1																			1
Chronic bronchitis		3	1	2	3		1		2	1	1	1	1	5	3					1	25
Emphysema														2							2
Undiagnosed x-ray shadows of lung																			1		1
Diseases of digestive system																					
Disease of teeth																1		1			2
Peptic ulcer												1			1						2
Dyspepsia (unspecified)			1						1	1			1			1	1			2	8
Inguinal hernia		2												1	2						5
Hiatus hernia															1					1	2
Constipation										2		1						1	5		9
Other digestive diseases					1				1	1											3
Cholelithiasis									1												1

	KNOWN BEFORE SURVEY										NEWLY FOUND AND REQUIRING TREATMENT										
	MEN					WOMEN					MEN					WOMEN					
Ages	50	55	60	65	70	50	55	60	65	70	50	55	60	65	70	50	55	60	65	70	Total
Genito-urinary diseases																					
Pus cells in the urine ŒŒ			1						1	1					1			1	1	2	8
Stricture			1																		1
Prostatic enlargement					2										1						3
Hydrocele		1													2						3
Impotence		2																			2
Utero-vaginal pro'apse						1			1								1			2	5
Dysmenorrhoea																1					1
Menopausal symptoms																	1				1
Cervicitis																1				1	2
Stress incontinence of urine																2	1			1	4
Dyspareunia																	1				1
Fibro-cystic disease of breasts									1										1		2
Skin diseases																					
Eczema		1	1	1	1					1	1	4		1	2			1		1	15
Seborrhoea															1				1		2
Psoriasis		1																			1
Nails diseased										1									1		2
Pruritis															1	1					2
Corns, callosities, etc. of feet												2	1	2	3		2	2	7	6	25
Other skin diseases														1							1
Diseases of bones and organs of movement																					
Rheumatoid arthritis (sero +)				1									1	1	2		2	1		1	9
Osteo-arthritis/arthrosis		2		1			2	1	3	3				1			1		3		17
Muscular rheumatism and fibrositis												1									1
Psoriatic arthropathy		1																			1
Hallux valgus and varus																		1		1	2
Other diseases of organs of movement		1			1																2
Fractured ribs											1										1
Lumbar disc lesion				1																	1
Symptoms and ill-defined conditions																					
Weight loss (unexplained)														1					1		2
TOTALS	1	24	8	24	22	7	18	6	28	36	8	25	15	34	41	17	25	21	43	43	446

79 95 123 149

174 272

446

Number of patients examined—104 = 4.4 diseases each
Patients with no disease, known or discovered = Nil
Patients with no new disease discovered = 3
Patients thought to be fit, but disease found by survey = 19

• Footnote: Obesity = more than 10% over the ideal weight given by Bornhardt's formula, i.e.: $\frac{\text{Ht. (cms)} \times \text{Chest (cms)}}{240} = \text{kg.}$

PART V

Environmental Hygiene

Food and Milk

Water Supplies

Sewerage and Sewage Disposal

FOOD AND MILK

Food hygiene is supervised by district medical officers of health and the public health inspectors, but, with the exception of Torquay, sampling of food under the Food and Drugs Act, 1955, is undertaken by this department.

There are five sampling officers in the county, whose function it is to procure samples of any food which is sold for human consumption and they are supervised by the county health inspector. Food and Drugs Act samples, other than milk, are sent to the Public Analyst for examination, but the majority of milks are subjected to the gerber test in this department and only the suspicious samples are submitted to the Public Analyst.

During the year, 2,371 formal and informal samples were taken. 137 milk and 851 other commodities were submitted to the Public Analyst and the remaining 1,383 (all milks) were examined by the gerber test in the laboratory attached to this department.

The samples submitted to the Public Analyst represented a wide range of foodstuffs and medicines, including ice cream, sausages, spirits and various proprietary medicines, drugs and vitamin preparations.

The Public Analyst reported that of the 988 samples he received, 83 were either adulterated or gave rise to some other irregularity. 55 of the samples were of milk and 24 of these were ones in which the non-fatty solids and/or butter fat was below the normally accepted figure, but investigation in each case showed that the milk was being sold in the same condition as it came from the cow and that no offence under the Food and Drugs Act was being committed. The remaining 31 samples of milk were found to contain added water in varying amounts and four vendors were prosecuted.

The remaining 28 samples other than milk reported on by the Public Analyst included a chocolate cake containing a piece of steel, two pork pies and one steak pie which were contaminated by mould, a chocolate truffle containing a cockroach, a packet of frozen beans found to contain a piece of woodlike substance, a bottle of school milk containing fragments of glass, a French sponge sandwich contaminated by mould, a school consignment of chipolata sausages found to have fermented, a bottle of milk containing a knuckle bone, a meat patty which was contaminated by mould, corned beef containing a piece of soft solder, lemon juice with a growth of mould, butter which was rancid and contained an excess of water, black pudding containing a loop of string, cocktail pies contaminated by mould, bread containing a piece of metal, butter containing traces of material having the characteristics of separator slime, sliced bread contaminated by mould, bread containing jute fibres, rock con aining pieces of iron wire, iced sliced cake which was contaminated by m uld, bread containing mouse excreta, a chocolate swiss roll with rancid filling, a bottle of milk containing coal dust, sausages containing preservative which had not been declared, a packet of frozen peas containing a slug, Glauber's Salt which was stated to be exsiccated sodium sulphate and substance in a dough cake which was found to be a compact mass of caramelised sugar. Nine of these cases resulted in prosecution and similar action was recommended in other cases; warning letters were sent in nine other instances.

The sampling officers take their samples with very considerable care and selectivity. Apart from the help given in this department, they are assisted and advised in their choice of samples by consultation with the Public Analyst and by a close study of the reports issued by the Public Analysts of other counties and published accounts of the legal action taken by other Food and Drugs authorities.

All complaints of alleged infringements of the principal Acts or the many Regulations, etc. made under it are very carefully examined. The co-operation of the public and of other local authorities is welcomed and I hope that this assistance will increase in the future.

Brucella Abortus

Towards the end of 1963, a sampling programme was initiated to determine the degree of infection by this organism in the milk sold for human consumption, and sampling continued through 1964, 1965 and 1966. The results of the sampling carried out during the year under review were as follows:

Total number of samples submitted	1,171
Number positive on Ring Test but negative on culture	164
Number positive on culture	34

Immediately a positive culture was known, the medical officer of health for the district was informed and steps were taken to prohibit the sale of the infected milk and to trace the offending animal or animals. Normally, two consecutive negative results are required before the raw milk is allowed to be consumed again and the number of samples taken is increased.

Biological Examination of Milk for the Presence of Tuberculosis

During the year a total of 1,171 samples was submitted, special attention being paid to milk to be sold unpasteurised. There were no positive results. The figures for the preceding 14 years are as follows:

Year	*No. of samples*	*Positive Results*
1952	781	11
1953	475	3
1954	1,028	12
1955	1,941	5
1956	959	0
1957	831	4
1958	1,107	2
1959	905	2
1960	679	0
1961	627	0
1962	666	0
1963	721	0
1964	865	0
1965	964	0

The Milk (Special Designation) Regulations, 1963

These Regulations, which came into force on September 29th, 1963, gave to the County Council the duty of licensing every dealer in designated milk; this work had previously been carried out by the public health departments of 47 district councils. The task of supervision and control by one authority was, therefore, a formidable one.

It has meant the annual inspection and general approval of the premises and milk handling facilities of 818 dealers and a comprehensive sampling programme is now in being.

During the year the following samples were submitted:

Pasteurised	*TOTAL*	*No. failing Phosphatase test*
	1,041	nil
Untreated	*TOTAL*	*No. failing Methylene Blue Test*
	535	35
Sterilised	*TOTAL*	*No. failing Turbidity Test*
	25	nil

When a sample fails to pass the prescribed test, an immediate inspection of the dealer's premises is made and repeat samples are taken where necessary. If it is thought that the failure, in the case of untreated milk, is the fault of the producer, the Ministry of Agriculture, Fisheries and Food's Divisional Milk Officer is informed.

The Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949

The County Council issued licences to the six pasteurising plant operators remaining in the county and a very careful watch is kept both on the plants and the processed milk. This involves regular inspections and samples are submitted for laboratory examination at very frequent intervals. 121 samples were taken from these plants during the year, 2 of which failed to pass the Phosphatase Test.

Additional checks on the quality of the processed milk are afforded by the routine sampling of milk supplied to the schools in the county, as a very large proportion of school milk is derived from these plants.

SCHOOLS

Milk in Schools Scheme

The tendering and three-year contract system of supplying the schools with milk which commenced in 1955 has worked with great success as far as this department is concerned. 536 schools in the county receive milk, including private schools; only 4 of this number are receiving raw milk, the remainder being supplied with pasteurised milk. Every effort was made to find a supply of pasteurised milk for the 4 schools in question, but largely on the grounds of distance and excessive cost it proved impossible to arrange.

School Swimming Pools

I welcome the rapid progress which is now being made with the provision of swimming pools for schools throughout the county. Most of them are of the learner type but a few, particularly in the larger secondary modern schools, are large enough for the advanced swimmer. At the end of the year 112 pools had been completed and a considerable number are contemplated for the following summer.

The Education Committee are prepared to consider grants of £250 for primary school pools and £500 for secondary schools, or half the cost—whichever is the smaller. In most instances the Head Teacher has been able to raise the balance from voluntary sources, e.g., parent-teacher organisations.

This rapid increase in the number of school swimming pools has meant a considerable extension of the work of the department. The sampling officers visit every school once a week and obtain a sample of water for bacteriological examination. If this sample is the subject of an adverse report, the County Health Inspector visits the school immediately and offers the appropriate advise.

The all-important consideration is to maintain a satisfactory level of residual chlorine in the pool at times of peak load, and our experience has been that this can only be achieved in the hand-dosed pool by continual checking and the repeated use of booster doses of hypochlorite solution throughout the day. This supervision will undoubtedly occupy a certain amount of the time of an already busy Head Teacher, but it is a responsibility which cannot be shirked if the pool is to remain an asset rather than a danger to the health of the children.

On a number of occasions the samples from a minority of pools (which, of necessity, have to be collected before lunch) gave unsatisfactory bacteriological results and if samples were to have been taken in the afternoon when the peak bathing load, allied to higher water temperature, was exerting its full effect upon the available chlorine, then undoubtedly the picture would have been worse. Spot checks on the chlorine residual in the pools were frequently carried out by the County Health Inspector and these only confirmed the truth of this statement.

It is clear that some Head Teachers do not realise how rapidly chlorine can be dissipated from pool water under the influence of warmth and bright sunshine, even when the pool is not in use: this action is immensely accelerated when the pool is being used, as each child contributes organic impurities which lock up and neutralise chlorine which would otherwise be available for killing germs.

My advice to Head Teachers is that it is a mistake to economise with chlorine; if they are hand-dosing, then the initial application of the day may well require hypochlorite solution at the rate of 3 pints per 10,000 gallons of pool water, with booster doses, whenever necessary, throughout the day of 1½ to 2 pints; these figures are given as a guide and will vary under individual circumstances. Testing need not be a time-consuming operation; the appropriate test can be carried out in ten seconds and there is no excuse for children using a pool without a chlorine residual of at least .5 parts per million.

Milk

The Divisional Milk Officer of the Ministry of Agriculture, Fisheries and Food informs me that, at the end of 1966, there were 7,332 registered milk producers, a decline of 327 on the previous year. It is interesting to note that of this decline, 70 were due to the boundary revision which returned the parishes of North Petherwin and Werrington to the Cornwall County Council. 621 licences permitting the sale of "Untreated" milk by producer/retailers were in operation, a decline of 4 during the year.

The Divisional Veterinary Officer of the Ministry of Agriculture, Fisheries and Food reports as follows:— "1966 on the whole may be considered to have been satisfactory from an Animal Health Division point of view.

During the year 277,183 cattle were tested revealing 94 reactors of 0.03% of animals tested. This compares with 1965 when 299,680 were tested revealing 58 reactors or 0.19% of animals tested. Although the number of reactors in 1966 showed an increase it was mostly confined to disease in two to three herds, where the trouble has now been eradicated, there being no cause for alarm.

With regard to Swine Fever this has shown a great improvement. There were five reported cases and all were negative. In 1965 there were 31 cases reported of which 4 were confirmed.

In 1966, 84 cases of Anthrax were reported but disease was only confirmed in 2 cases. There were 75 reported in 1965, 28 of which were confirmed.

Regarding Fowl Pest, no reported cases were received during the year under review, while in 1965 there were 4 negative cases and 4 confirmed cases.

With regard to Foot and Mouth disease, there was 1 negative case in Devon during 1966, while the wholetime veterinary staff were concerned with 12 consultation cases.

The Poultry Health Scheme, which took the place of the Poultry Stock Improvement Scheme came into operation on 1st January, 1966, attracted 75 flocks. During the year 103,656 were tested for Pullorum disease.

The Free Calfhood Vaccination Service has again been successful in 1966, there are now 7,648 registered herds. During 1966, 48,479 doses were used compared to 41,420 in 1965 and 31,496 in 1964.

I would like to record my thanks to Dr. Lyons, his Medical Officers of Health and the Public Health Department for their excellent co-operation."

WATER SUPPLIES

Water Boards in the county have all been active during the year and all have substantial schemes, either in course of construction or awaiting the consent of the Ministry of Housing and Local Government. This progress is emphasised by the amount of precept which each Board makes on the county council

Comparative figures are as follows:

	1964/65 *Actual Cost*	1965/66 *Actual Cost*	1966/67 *Probable Cost*
North Devon Water Board	.. £223,355	£240,523	£194,125
South West Devon Water Board	£43,342	£4,802	£46,825
East Devon Water Board	£92,738	£30,604	£28,550

The North Devon Water Board now covers an area of 1,646 square miles; approximately 1,245 miles of mains have been laid and the average quantity of water supplied is over 8.6 million gallons per day. The total capital expenditure incurred by the Board up to 31st March, 1966 was £7,140,005.

The South West Devon Water Board was formed under Ministerial Order to operate from 1st October, 1963, and it took over the water undertakings of the South Devon Water Board and of the Boroughs of Torquay and Totnes; the Urban Districts of Ashburton, Brixham, Buckfastleigh, Dawlish, Paignton and Teignmouth; the Rural District of Newton Abbot and part of the Rural District of St. Thomas lying to the south of the River Exe. The statutory area is approximately 500 square miles and the total amount of water produced in 1966 was 4,378 million gallons. The total capital expenditure to the 31st March, 1966 was £6,591,641, including the book value of assets transferred undder the Order. The outstanding debt at the 31st March, 1966 was £4,144,118. Up to the 31st December, 1966 the new Board had laid 92 miles of mains.

The East Devon Water Board was reconstituted on the 1st October, 1964 and now comprises the authorities of the original Board, together with the County Borough of Exeter, Budleigh Salterton, Exmouth, Seaton and Sidmouth, the whole of the St. Thomas Rural District area east of the River Exe and the Water Undertaking of the Colyton Feoffees. The total capital expenditure of the authorities included in the Board amounted to £4,384,848 at the 31st March, 1966. Of this figure £1,742,929 was incurred by the Board itself and £2,641,919 represented the debt of transferred undertakings.

During the year 1966 the Board embarked on a programme for the sinking of 7 boreholes in order to augment the source of supply. 3 of these will be at Dotton, 1 at Ottery St. Mary and 3 in the parishes to the north of Exeter.

During the year 1965/66 the Board spent a total of £161,098 on various capital projects, including water mains, reservoirs, boreholes, etc.

During the year grants under the Rural Water Supplies Acts were agreed to in principle on the following schemes:

Local Authority	*Parishes or Areas Affected*	*Estimated Cost*
South-West Devon Water Board	Strete	£1,600
	Woodland and Woodland Cottages and Purcombe	£19420
,,	Woodland and Purcombe Farm, Broadhempston	£1,700

Sewerage and Sewage Disposal

The following schemes submitted to the County Council for financial assistance were examined by the County Health Inspector and recommendations in each case were made to the Appointments and General Purposes Committee:

Local Authority	*Parishes or Areas Affected*	*Estimated Cost*
Ashburton U.D.C.	Trunk sewer	£14,500
Axminster R.D.C.	Dalwood	£37,400
,,	Hawkchurch	£2,560
,,	Membury and Rock	£33,125
Barnstaple R.D.C.	Bishopstawton, Landkey and Swimbridge	£201,770
,,	Milltown and Muddiford	£25,500
Crediton R.D.C.	Cheriton Fitzpaine	£44,100
,,	Puddington	£19,800
Dawlish U.D.C.		£207,799
Great Torrington B.C.	Calvesford Road	£4,500
,,	Town Park	£4,118
Holsworthy R.D.C.	Pyworthy and Derril	£26,800
Honiton R.D.C.	Feniton and Sidmouth Junction	£41,700
,,	Upottery	£11,300
Newton Abbot R.D.C.	Chudleigh Knighton	£51,600
,,	Combe-in-Teignhead and Stoke-in-Teignhead	£182,700
Newton Abbot R.D.C.	Denbury	£65,000
Newton Abbot U.D.C.		£660,400
Northam U.D.C.	Myrtle Street, Appledore	£8,500
Plympton R.D.C.	Elburton	£151,500
,,	Heybrook Bay, Down Thomas and H.M.S. Cambridge	£118,000
,,	Wembury	£313,000
Salcombe U.D.C.		£235,000
Seaton U.D.C.		£182,000
South Molton R.D.C.	Molland	£2,445
Tavistock R.D.C.	Lewdown	£39,200
,,	Walkhampton	£29,082
Teignmouth U.D.C.		£37,709
Torrington R.D.C.	Weare Gifford	£52,300
Totnes R.D.C.	Galmpton	£38,460

PART VI

MISCELLANEOUS SERVICES

Capital Building Programme

Health Centres

Clinics

Ambulance Stations

Junior Training Centres

Hostel Accommodation—Children

Adult Training Centres

Hostel Accommodation—Adults

Accommodation For District Nurse/Midwives

CAPITAL BUILDING PROGRAMME

HEALTH CENTRES

A health centre is a building in which family doctors have their consulting rooms where the local health authority has its clinic and where officers of health and other social work departments may be based or have interview facilities. There is thus a drawing together of those engaged in the community health and welfare service which can only be of benefit to all concerned.

Certain hospital functions may also be conducted from a health centre.

A great deal has been written about the family doctor, the waste of his valuable medical time by working in poor accommodation, often with inadequate equipment and lack of clerical and ancillary help. The recently awarded government grants towards premises and staff will be of benefit to general practitioners, but it remains a matter of importance that satisfactory accommodation, together with clerical and other ancillary help, should be provided in the most economical manner possible. It is surely preferable for the doctors and the local health authority to share accommodation, equipment and clerical help, rather than for individual practitioners and the authority each to provide their own premises. Furthermore, the policy of attaching or closely connecting to the general practitionery such ancillary staff as health visitors, nurses, midwives, mental welfare officers, etc., will be of even greater value in a health centre where liason can be achieve easily without the necessity for time-consuming journeys, or repeated ineffectual telephone calls.

The premises to be provided by the County Council will be let in the first instance to the Executive Council, who will re-let to the general practitioners. The Executive Council remains responsible for rent and thus ensures permanency of letting. The basic rent is assessed by the County Treasurer on the room of which the doctors have exclusive or shared use, together with an extra amount representing repairs and redecorations. In addition, the Executive Council pays a proportion, again according to use, for equipment and running expenses, including rates, heating, lighting, cleaning, telephone, etc. The basic rent and rates are the subject of a government grant, as will be the doctors' share of clerical assistance. Thus both the County Council and the doctors, by sharing the premises, are able to use very satisfactory accommodation at a cost which is considerably less to each than it would be for buildings erected for independent use. At some of the smaller places a clinic purely for local health authority purposes would be exactly the same size as that now being erected for shared use with the general practitioners. This in itself highlights the economies as far as the County Council is concerned.

Clerical staff are interviewed and appointed jointly by the general practitioners and a senior local health authority doctor.

Health centres are being planned in various towns and villages in Devon the minimum criteria generally being as follows:

(i) Approval of the general practitioner(s) already practising in the area.

(ii) The need for new maternity and child welfare clinic facilities; this is dependent upon existing accommodation, overall population, the annual number of births, and the number of children under the age of 16 years.

Although these minimum figures are not hard and fast, the following is an estimated guide:—

Overall population	2,500
Annual number of births	40
Number of children under 16 years	600

Progress

Throughout 1966 steady progress was maintained with the planning of health centres in many parts of the country. The early enthusiasm of general practitioners showed no signs of abating, and by the end of the year four centres were operational, three were under construction, and a further six had received all the necessary consents and tenders were about to be invited. Planning and negotiations with general practitioners and the Executive Council had reached an advanced stage in respect of an additional nine health centres, whilst schemes for a further eleven were being discussed.

FUNCTIONING HEALTH CENTRES

Ottery St. Mary

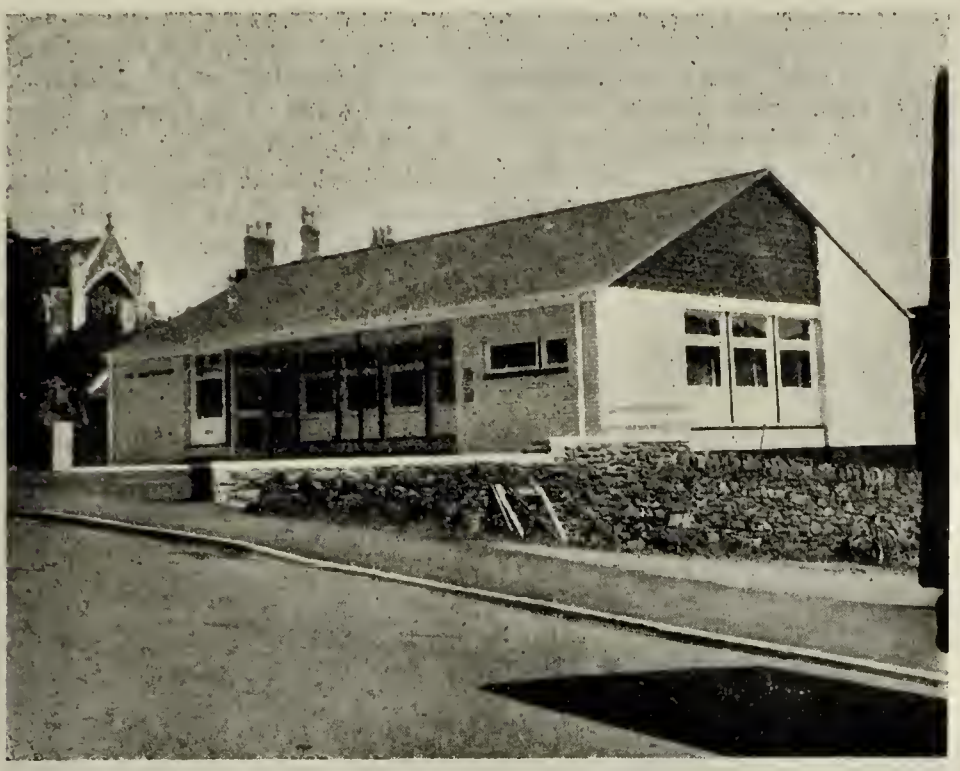
This became the first operational health centre in Devon on 1st July, 1965, and in spite of not being entirely purpose-built has worked extremely smoothly to the delight of the general practitioners and county staff.

Buckfastleigh—the Timms Health Centre

This health centre was officially opened on 18th May, 1966 by Dr. Shaw, the deputy chief medical officer of the Ministry of Health, and was named after the chairman of the health committee, who at the time was also chairman of the urban district council. The building was not, however, finally ready for occupation until 16th June, 1966, but apart from certain teething troubles connected with its construction it is proving very satisfactory.

Lynton

This is a small health centre for two general practitioners and local authority services, and was brought into operation on 7th November, 1966.The centre is situated in the grounds of the Cottage Hospital and has been spoken of enthusiastically by all concerned.



Okehampton

The existing clinic in the hospital grounds was extended to provide accommodation for the four general practitioners, and became operational on 5th September, 1966. It became clear before opening that the reception office was going to be too small. Its original size had been limited by the amount of available hospital land, but during construction the architect was forced to make a small but significant change in the position of the officer counter, and this resulted in a critical reduction in the amount of floor space. The hospital authorities have, however, been most co-operative and have agreed to sell to the County Council a small additional strip of land which will allow the office to be extended. It is anticipated that this work will be carried out early in the new year.

HEALTH CENTRES UNDER CONSTRUCTION at 31st DECEMBER

Ilfracombe

Construction work commenced in April, 1966, and the building is due to be completed in April 1967.

Seaton

Construction commenced in September 1966, and the building is due to be completed in June 1967.

Ipplepen

Construction work commenced in August 1966, and the building is due for completion in March 1967.

HEALTH CENTRES APPROVED FOR ERECTION IN FINANCIAL YEAR 1966/1967

Budleigh Salterton
Cullompton
Ashburton
Great Torrington
Kingsteignton
South Molton

By the end of the year consents for the erection of a health centre at each of these towns had been received from the general practitioners, Executive Council, and the Ministry of Health. It is anticipated that tenders will be invited early in the new year.

Site acquisition

At the beginning of 1965 sites for health centres other than those mentioned above, were in the ownership of the county council at Plympton, Colyton, and Combe Martin. Owing to the pending boundary change the site at Plympton will not be developed by the county council, but will be passed over to the Plymouth City Council, whom it is hoped will undertake this work themselves. It is expected that a small piece of additional land will be acquired at Combe Martin to provide an improved access to the site.

Sidmouth

A delightful central site was acquired close to the hospital. By the end of the year the plan had been agreed with all six general practitioners, and the scheme was about to be submitted to the Ministry of Health.

Torquay

A site close to the centre of the town was acquired, and this, together with a site in the Shiphay area of the borough, will be handed over in due course to the proposed county borough. This arrangement has been carried out in the closest co-operation with the Torquay council and the proposed county borough co-ordination committee.

By the end of the year negotiations were continuing for sites at Northam, Ivybridge, Chudleigh, Dawlish, Salcombe, Kingsbridge, Holsworthy, Totnes, Yealmpton, and Yelverton.

Discussions were continuing with the general practitioners, the Executive Council, and the urban district council over the siting of a centre at Exmouth.

CLINICS

If health centres cannot be erected then clinics should be provided containing not only health department services, but also those of the welfare, children's, education and perhaps probation departments. This is essential to help effect liaison between the services of these departments which can overlap in the fields of the elderly, children's welfare, handicapped persons, problem families, and the unmarried mother, etc.

A social services sub-committee of the establishment committee meeting to discuss administrative arrangements in the children's, health, education and welfare departments, resolved that all social workers in these departments should be based wherever possible in the same offices.

All future clinics in Devon are being planned so that it will be possible to add an extension to provide accommodation for general practitioners if they should elect later to join a health centre.

A survey of existing hired clinic accommodation showed that although some places are tolerable, conditions in others are quite deplorable. Some of the conditions found are as follows:

(1) Several premises were very dirty and, because of age and dilapidations, impossible to keep clean.

(2) Water closets often out of action and frozen in cold weather.

(3) Buildings so poorly heated that babies and toddlers could not be examined except in warm weather.

(4) Complete lack of privacy and sound-proofing so that no matters of a confidential nature could be discussed.

(5) Dangerous stairs and steps which were hazardous to mothers carrying babies, elderly persons, expectant mothers, and toddlers.

(6) Inadequate means to provide hot water.

(7) Cramped conditions. In one instance the doctor had to sit in a wash-room immediately outside the lavatory which is used by the public attending the clinic.

(8) In one place which is also used as a club, evidence of the previous night's revelry may still be found.

The Kitchen

Child Welfare in the Barn

Doctor's Consulting Room with access to public lavatory

Trying to keep Warm

Dangerous Stairs

The Pram Shelter

The Old Look

The New Look

Progress

No building work was carried out on new clinic projects during 1966. Temporary accommodation was sought in the Tavistock, Totnes, and Teignmouth areas, and also in the Plympton area, to house staff who will still be based in this area after it has been transferred to Plymouth. Considerable progress was made in this direction, but by the end of the year only that at Teignmouth was actually being used.

Bovey Tracey

This clinic received the promise of loan sanction from the Ministry of Health, and it is anticipated that tenders will be sought in the early part of the new year. This building has been so designed as to allow easy extension, should the local doctors wish to have accommodation later.

Tiverton

An urgently needed extension to the existing clinic received Ministry of Health approval and the promise of loan sanction, and by the end of the year tenders were being sought.

Tiverton—site for new clinic or health centre

During the year a site was approved by the Health Committee adjacent to the Belmont Hospital. A replacement clinic is planned for the financial year 1971/72, and it is hoped to erect a building which will allow easy extension to provide accommodation for the general practitioners at a later stage. Agreement has been reached to make provision in this building for social workers and allied staff of the children's, welfare, and education departments.

Totnes

This clinic, which will also have social workers of other departments, was further held up during 1966 owing to the credit squeeze. There is the possibility that this building may be erected as a health centre and the possibility of re-siting it on a more central site is being investigated.

Kingskerswell

No further progress could be made here on account of the credit squeeze.

AMBULANCE STATIONS

Bideford ambulance station was completed in 1965.

In the post-war period, ambulance stations have been provided at Crediton (1963) and at Plympton (1960). In addition a further nine ambulance stations have been provided by voluntary organisations at Ashburton, Axminster, Combe Martin, Dartmouth, Honiton, Okehampton, Sidmouth, South Molton, and Torquay.

No new building work was carried out on ambulance stations in 1966.

JUNIOR TRAINING CENTRES

These have been provided since the war at:

	Day Pupil Places	*Residential Places*
Barnstaple, Abbeyfield	60	30
Dawlish, Oaklands Park	48	43
Paignton, Mayfield	48	—
Plymstock, Downham	48	21
Total	204	94

Paignton, Mayfield

Building work was commenced in 1966 to provide a manual instruction room, and an additional 12 places, together with a special care unit, the capital cost of the latter being generously donated by the National Spastics Society.

Plymstock, Downham

Work was started in 1966 on the extensions which will provide an additional 12 places, a kitchen, new dining hall, and manual instruction room. A special care unit and further extensions are urgently required in this area.

HOSTEL ACCOMMODATION FOR CHILDREN

No additional places were provided in 1966.

ADULT TRAINING CENTRES

Barnstaple

Final completion of the new purpose-built 120-place Adult Training Centre took place in the early part of 1966.

Exmouth

This urgently needed 90-place adult training centre was commenced in the early part of the year, and was completed just before Christmas, thus meeting the deadline of 31st December when we had to vacate the hired accommodation.

Paignton, Hollacombe

By the end of the year tenders had been invited for doubling the size of this adult training centre to provide a total of 120 places.

Tavistock

The County Architect hopes to invite tenders in January 1967 for the provision of a 50-place adult training centre.

Axminster

During the year the Ministry of Health indicated that the plans for the adult training centre and hostel were satisfactory and that loan sanction could be anticipated in the financial year 1967/68.

HOSTEL ACCOMMODATION FOR ADULTS

Marldon, Nr. Paignton

This 23-place hostel is just outside the area which will form the new proposed Torbay County Borough and will thus remain under County Council administration. The sewage disposal system had proved inadequate and arrangements were being made during the year for this to be remedied. The hostel remained full throughout the year.

Barnstaple

The main house, a former chest hospital, was brought into operation early in the new year as the men's section, but building work on the outside pavilion was not completed until October 1966. This now forms the women's section, and the whole provides 29 beds. Both sections of the hostel filled steadily and the premises were soon full. The staff accommodation is inadequate at Barnstaple and it is hoped to erect a staff bungalow in the grounds as a matter of urgency.

SITES FOR ADULT TRAINING CENTRES AND HOSTELS

Sites were acquired as follows:

(1) Kingsteignton for a new 120-place adult training centre and 26-place hostel.
(2) Kingsbridge for a 50-place adult training centre and 30-place hostel.
(3) Holsworthy for a 50-place adult training centre and 30-place hostel.

Negotiations still continued for a site at Crediton on which to replace the existing temporary centre.

SHELTERED WORKSHOP

A prefabricated building which started life during the last war as a day nursery and since then has also been used as a junior training centre and more recently as an adult training centre, became in November 1966 a sheltered workshop. This can only be a very temporary measure as the building is in a very poor state. A site has been acquired for a new sheltered workshop and it is hoped to commence building in 1967.

ACCOMMODATION FOR DISTRICT NURSE/MIDWIVES

It was mentioned in last year's report that an experimental large district room, together with lavatory and waiting accommodation is being provided in certain bungalows, so as to give the county chiropodists satisfactory working conditions in small villages where other clinic facilities are not justified. This has proved to be most valuable so that at a cost probably no greater than that of hiring a hall a chiropodist can work in pleasant surroundings without interference to the privacy of the nurse.

Building construction was commenced or completed on housing units as follows:

Bampton
Bideford—2 units
Buckfastleigh—flat over health centre
Seaton—2 units
Winkleigh

The following housing units were purchased:

Barnstaple—2 units
South Brent

PART VII

Child Health Services

The Health of the School Child

The Annual Report of the Principal School Medical Officer, including

The Report of the Principal School Dental Officer

CHILD HEALTH SECTION

SCHOOL HEALTH SERVICE

HANDICAPPED CHILDREN

JUNIOR TRAINING CENTRES AND HOSTELS

DAY NURSERIES AND CHILD MINDERS

SPECIAL FAMILIES

LIAISON WITH OTHER DEPARTMENTS

The child health section was introduced in 1961 and covers all local authority health services available to children between the age of two years and school-leaving age. There is, of course, no hiatus at the extremes, liaison with the maternity and infant welfare and adult health sections being close and continuous. This administrative division is unusual in that it includes the community care of mentally handicapped children, a service more often included in the mental health sections of health departments. Here in Devon, by having a more comprehensive child health section, we ensure that these handicapped children receive continuity of care and are dealt with by the same professional and administrative staff between the ages of two and sixteen, thus emphasizing our belief that these children should not be cut off from the main stream of community child care.

In the field, the care of all children from birth to sixteen is the special responsibility of both assistant county medical officers and health visitors, and while help and supervision are still available through them after this age, this is supplemented in the case of handicapped children by social workers from the adult health section who assist in effecting liaison with youth employment officers, disablement resettlement officers and others operative in the adult working world.

On the central staff there is a senior medical officer responsible under the county medical officer for the administration of the section, assisted by a senior assistant medical officer who does all work connected with Day Nurseries and Children Minders, the superintendent health visitor, a health visitor experienced in the care of special families and clerical staff of four dealing with detailed administration of the separate sub-sections. We are fortunate in having an excellent clerical staff who give unstinted hard work and loyalty to the section.

The work of the section increases steadily, but unfortunately the number of staff in the clerical section does not. This results in a heavy workload for all staff, with inadequate reserve for emergencies, illness or holidays.

The immediate need is for an administrative assistant to relieve the present staff of routine administration of the four junior training centres.

SCHOOL HEALTH SERVICE

The work of the school health service has been handicapped in some areas, particularly the south west of the county by shortage of staff.

The work which the school medical officer is called upon to do becomes more diverse. Ascertainment of handicapped pupils becomes an increasingly important and time consuming task—it demands the most careful and thorough work to ensure that a child has been thoroughly assessed and correctly placed. Further the school medical officer must do medical examinations for teachers and teaching candidates, special examinations, health education talks, confer with head teachers, attend case conferences, examine school buildings, quite apart from investigation of any infectious disease outbreaks. All these tasks tend to erode away the time needed for routine medical inspection and immunisation procedures. As a result some school medical officers have had difficulty in completing their programme for the year.

Apart from their visiting work and attendance at medical inspections the health visitors and clinic nurses do much routine work in the schools. School children have an annual vision test and an annual hearing test. In some schools a termly hygiene examination is also considered necessary.

This work also gives the nursing staff a useful opportunity to talk to and appraise every child.

In few schools is it possible to have a medical inspection room, which is the ideal, and visits to the schools by the many and various members of the school health service must at times cause difficulties and disruption, especially in the smaller ones. The goodwill and co-operation of head teachers, which is invariably found, is much appreciated. Nevertheless, the dissatisfaction of all medical officers at the conditions under which they are expected to work, must be recorded. Even in new primary schools a purpose-built medical inspection room is not included, and inspections have to be done in a room vacated for the occasion by the school secretary or headteacher.

Administration

The numbers of children on the school registers are as follows:

Primary Schools	42,843
Secondary Schools, Grammar Schools, and Comprehensive Schools	28,693
Special Schools	407
Total	71,943

Direct control of this service is vested in the school health sub-committee of the education committee, and we are particularly fortunate in this county in the friendly and effective liaison between education and health departments.

There are twenty-three school medical officers in the field, eighteen of whom are part-time and seven of these hold mixed appointments as assistan county medical officer and district medical officer of health. They arrange their own school programmes and are responsible for advising head teachers of impending school medical inspections. Needs vary widely in a county of such size and diverse nature as Devon and a delegate function such as this has much to commend it. All school medical officers have a degree of independence which encourages interest and responsibility and allows the development of varied skills.

A medical officer reports:

"When a medical officer has been long resident in one area and made a career of his clinical screening and advisory work this makes things so much easier, because the new parents of today he often knew as the school-children of former years. Their children he has seen regularly at the Child Welfare Clinic, and they are familiar with his manner and with his appearance, with his medical instruments and even with his clinic toys. School Medicals therefore become an extension of this work in a different building. When one has the child's clinic records, the health visitor's notes and the hospital reports available, the teacher and parent can be advised about development and management. If one can foster this friendship in the secondary school years by joining in discussion groups, then the Leaver medical with advice on physical suitability for specific jobs, etc., is taken for granted. Although the Appointed Factory Doctor Service is not yet integrated with the School Health Service, some of us take an active interest in the Youth Service and here again one often renews friendships with former school-children on Youth Leader or Senior Members' Courses or even on Preparation for Marriage Courses. A medical advisory service is therefore available for the full span of difficult years—from infancy to adulthood.'»

To enable us all to benefit from such individual experience and to guard against insolation as well as to discuss matters of general interest, the county medical officer holds a central meeting of all medical staff three times a year. These meetings are held in different areas of the county, and are followed by a talk by an invited speaker, or a visit to a place of interest. As a further means of exchanging ideas, the senior school medical officers of Plymouth, Exeter, Cornwall and Devon also meet three times a year and find it most useful to discuss problems and compare experiences.

School Medical Inspections

The compulsory school medical examination of school entrants remains the keystone on which the school health service is built. It may be the first complete medical examination the child had had and its value is heightened by the opportunity afforded to the parents to discuss with the school medical officer any problems which they have concerning the child. Some medical officers use the selective system for examination of intermediate age groups, others continue with the examination of all pupils at this age. This is a decision for the individual preference of the medical officer concerned and is still a matter of some controversy. Those who use the selective system find it rewarding in that they are able to spend more time with children having a definite symptom; those who examine all children routinely feel that defects may be missed if selection for examination is made on the basis of a complete questionnaire, or the recommendation of the school nurse or teacher. All children have a third medical inspection before leaving school. The general trend of less physical defects and more emotional problems is especially noticeable at this medical inspection; with a need to spend more time with each child.

The frequency of visits to each school varies. Some medical officers are arranging with head teachers to divide up the year's work so that the medical officer visits the schools each term routinely and is thus able to establish a much closer liaison with both pupils and staff. It has not been possible for all medical officers to complete their school work within the year.

School Medical Records

Mention was made in last year's Annual Report of the concern of medical officers that these records were kept in schools and not in clinics. In September

1966 a pilot scheme was initiated in which records from the Tavistock area were placed in the clinic. This has proved most successful, and it is to be hoped that this will soon be the procedure throughout the county.

Dr. Budding reports:

"In the autumn a Pilot Scheme was started in the Tavistock Area, to keep all Medical and Dental Records and Cards in the Clinic.

Preparation for this started before the end of the school holidays, and with the assistance of the Education Welfare Officer and School Nurse, all records plus filing cabinets were transferred to the Clinic.

The Head Teachers were notified of the impending change, by letter, and also a visit by the school medical officer a few days after, to clarify. With only one exception this was welcomed by all schools concerned (and this latter one has been converted now I think). The only work falling on the school head teachers and secretaries now is (*a*) to notify the Clinic of *all* entrants, mostly of course at the beginning of the term; (*b*) to fill in times of appointments on the appointment forms to be completed by parents.

The education welfare officer lets the clinic know of any transfers out and the clinic clerk gives him the appropriate records.

I must emphasise that with only 16 Primary Schools and 1 Comprehensive School, the amount of extra clerical hours required by the clinic clerk is considerable. Also, a certain amount of notifying has inevitably to be done within a short time, viz., at beginning of each term. The work could and should be lightened by the school nurse wherever possible, preparing the cards of all those in 8, 11-year-old and "Leavers" groups ready during the school holidays.

On the day of the school medical inspection the school nurse/health visitor or school medical officer takes the appropriate medical records to the school.

The school nurse and health visitor also take the records with them when vision testing/hearing testing. In a large school this can be difficult I imagine as it means transporting a few hundred cards, but so far it has been accomplished here with reasonable ease.

ADVANTAGES: 1. Records in clinic all time, to refer to on request from hospital (e.g. Tetanus), G.P., Chest Clinic, parent or school. (e.g. parents or school requests "on waiting list for speech, oculist, etc.").

2. Reports from hospitals/clinics can be recorded immediately by school medical officer.

3. Immunisation completion cards may be filed by school nurse immediately. (Both 2. and 3. mean that cards are up to date if child moves away from school or area).

4. *Confidentiality* is maintained.

5. The cards are always available, previously if, e.g., child had to visit dentist or oculist, records were often missing from school (and even for school medical officer's visit), for a week or so. Now this never occurs.

6. A surprising number of children had "missed" medical inspections for various reasons. All cards have been checked with school lists and medical inspection records are now fully up to date and will be kept so.

7. Hearing Assessment Clinic has all records to hand.

8. Any children requiring special treatment by schools, e.g., to sit near front for speech therapy, to have specialist appointment, child guidance clinic etc., have card 10M. completed and made out for the head teachers."

A—Periodic Medical Inspections

The number of children classified unsatisfactory will depend very much on the medical officer doing the examination. Different standards are held by different medical officers, and therefore these figures do not give a reliable guide to the standard of health of the children examined.

Age Groups Inspected (By year of birth)	*No. of Pupils inspected*	*Physical Condition of Pupils Inspected*	
		Satisfactory	*Unsatisfactory*
		No.	*No.*
(1)	(2)	(3)	(4)
1962 and later	116	116	—
1961	4,300	4,281	19
1960	3,050	3,038	12
1959	781	776	5
1958	2,307	2,298	9
1957	1,984	1,980	4
1956	697	686	11
1955	1,079	1,073	6
1954	1,594	1,588	6
1953	740	739	1
1952	821	818	3
1951 and earlier	3,880	3,881	7
Totals	21,349	21,274	83

B—Other Inspections

Number of Special Inspections	948
Number of Re-inspections	3,265
Total	4,213

C—Pupils found to require Treatment at Periodic Medical Inspections
(excluding Dental Diseases and Infestation with Vermin)

Notes: Pupils found at Periodic Inspections to require treatment for a defect are not excluded from Table C by reason of the fact that they were already under treatment for that defect. Table C relates to individual pupils and not to defects. Consequently, the total in column (4) will not necessarily be the same as the sum of columns (2) and (3).

Age Groups Inspected (By year of birth) (1)	*For defective vision (excluding squint)* (2)	*For any of the other conditions recorded in Part II* (3)	*Total individual pupils* (4)
1962 and later	—	14	12
1961	54	312	331
1960	44	215	227
1959	9	55	52
1958	52	190	189
1957	57	136	165
1956	17	68	60
1955	27	139	113
1954	73	196	190
1953	43	107	106
1952	59	111	144
1951 and earlier	146	271	341
Totals	581	1,814	1,930

Return of Defects by Medical Inspection in the Year ended 31st Dec., 1966

Note: All defects noted at medical inspection as requiring treatment ars included in this return, whether or not this treatment was begun before the date of the inspection.

Defect Code No.	*Defect or Disease* (1)	Periodic Inspections — *No. of defects*		Special Inspections — *No. of defects*	
		Requiring treatment (2)	*Requiring to be kept under observation but not requiring treatment* (3)	*Requiring treatment* (4)	*Requiring to be kept under observation but not requiring treatment* (5)
4	Skin	354	450	6	6
5	Eyes—*a.* Vision	581	491	9	5
	b. Squint	135	206	2	1
	c. Other	41	128	2	3
6	Ears—*a.* Hearing	97	625	4	4
	b. Otitis Media	58	481	3	6
	c. Other	8	64	—	—
7	Nose or Throat	149	1,365	5	4
8	Speech	104	334	2	3
9	Lymphatic Glands	8	418	—	4
10	Heart	17	193	4	3
11	Lungs	101	494	31	6
12	Developmental—				
	a. Hernia	11	63	—	—
	b. Other	48	293	2	7
13	Orthopaedic—				
	a. Posture	45	120	7	1
	b. Feet	160	392	5	4
	c. Other	114	475	8	6
14	Nervous system—				
	a. Epilepsy	49	55	2	2
	b. Other	30	125	4	—
15	Psychological—				
	a. Development	133	390	6	16
	b. Stability	86	615	9	12
16	Abdomen	22	138	5	2
17	Other	14	122	2	—

Infestation with Vermin (Head-lice)

Neither cleansing notices nor cleansing orders were issues during the year, the policy being that a friendly approach to the parents is more effective in the long run.

The schools in most areas are completely free from infestation, in others it is a constantly recurring problem. In 1966 there was a slight increase in infestation in some areas. A determined and energetic school nurse can do much to reduce the incidence, and it is to be hoped that with the easy, pleasant, modern treatment, infestation will soon become a thing of the past.

Infestation with Vermin

(i)	Total number of examinations in the schools by the school nurses or other authorized persons	110,754
(ii)	Total number of individual pupils found to be infested ..	384
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	—
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944) ..	—

Chiropody

Several medical officers report an increased incidence of verrucas in their areas. The County Chiropody Service has been able to help both with treatment and with foot inspections in schools.

One medical officer reports:

"While inspecting for verrucas a number of other foot conditions were found. We hope that it will be possible to continue to offer chiropody regularly in the school. This will reinforce our health education concerning the care of feet and the choice of footwear. In far too many instances foot hygiene was poor when an inspection was made without notice and many pupils, both boys and girls, were wearing shoes poor in design and quite unsuitable for school."

School Transport

At present a medical officer can recommend school transport as either essential on medical grounds, or as desirable on medical grounds. The latter recommendation is not usually supported by the Chief Education Officer.

Cases do arise where transport is essential on social grounds, e.g. escorting a 5-year-old deaf child whose mother has two younger children. This type of problem has been discussed with the Chief Education Officer, who gave the matter sympathetic consideration, and it is hoped that wider criteria can be laid down.

Nocturnal Enuresis

The electric alarm apparatus was out on loan during the year and continues to be of valuable service. If it does not actually produce 100 per cent cures in all cases it does demonstrate to the child concerned that he is capable of having dry nights. This realisation makes the child and the parents much happier and in one or two cases an improvement in the child's school work has also resulted. The family doctor is consulted in all cases before treatment is commenced. This group of children needs our help but unfortunately parents are often reluctant to bring them forward for treatment. There is no doubt, however, that the success obtained with the alarm has brought many mothers to the Clinic to enquire about it and ask for help.

We are using the alarm for five- and six-year-old children now, as well as for older children. It is just as effective with the younger children and usually the time required to establish control is much shorter than with older children.

Relationship with G.P.s

On the whole this is excellent, and medical officers are encouraged when they first take up their duties to visit all G.P.s in their area, making themselves known to facilitate later contacts. Any child found at a school medical inspection

to require treatment is referred to the G.P. by letter or 'phone, and where specialist advice is necessary a consultation form is completed and sent to central office: notice of this is sent to the G.P. with a proviso "If you have any objection to this course of action, please inform me within seven days. If I do not hear from you I shall assume that you have no objection, but if you have any further details of the child's medical history which you think may be of help perhaps you will be kind enough to send these to me or direct to the consultant. A copy of the consultant's report will be forwarded to you," which gives an opportunity to object but saves the G.P. any trouble in replying if he is agreeable.

ANCILLARY SERVICES

There are many services which, whilst disciplines in their own right, also provide ancillary help essential to the proper functioning of the school health service.

Child Guidance

There are three clinics in the county situated at Barnstaple, Torquay, and Exeter, the latter being a joint clinic with Exeter City. The teams are headed by psychiatrists who give varying amounts of time on a sessional basis. Children from the south-west of the county are referred to the Nuffield Clinic at Plymouth where Dr. Weeks sees them for us.

We were very sorry to lose the excellent services of Dr. W. Johnston, who left in the autumn to take up a post in Scotland. He had been responsible for the Child Guidance Clinic at Torquay, and as yet a successor has not been appointed. Dr. Gaussen has very kindly been seeing urgent cases at the Torquay Clinic since Dr. Johnston's departure, and we are most grateful for this help.

In addition to their ordinary work, the psychiatrists give much valuable time to meetings with health visitors and school medical officers to discuss cases of mutual concern and to advise on child guidance in general. This in-service training is of incalculable benefit and we are most appreciative of such constructive help.

Exeter Child Guidance Clinics

Dr. Gaussen reports:

"During the year under review, East Devon Clinic lost a large area around Exeter and children from Topsham, Pinhoe and Alphington are now seen in the City Clinic. This may account for the slight drop in referrals, but the Clinic has been very busy and the link with the hospital service through Dr. C. Wardle, Consultant in Child Psychiatry, will lead inevitably to larger numbers referred. One group of cases, those of school refusal, has caused us a great deal of concern and each one means much intensive work. Children who cannot go to school have broken down very considerably in their mental halth and the whole family is involved in their disintegration.

"We were very sorry in the summer to say 'goodbye' to Miss Pamela Bowmer who left us after ten years to become a lecturer at Keele University. For this post, she was very well fitted by her expereince with the County. We were fortunate in securing Miss Margaret Rossall to replace her, although this meant a loss to the Torquay Clinic.

"It may be noticed that the number of cases in residential treatment has fallen. This is because of the extreme difficulty of recruiting staff for working with maladjusted children in The Gables Hostel. The work there is of a specialised nature and is arduous, although rewarding. It needs staff of a particular calibre and education. Unfortunately, the deputy posts at the hostel do not carry a sufficiently high salary to make them attractive to suitable applicants."

Torquay Child Guidance Clinic

Dr. Gaussen reports:

"During the year under review, the number of cases referred continued to run at a high level.

"Much to the regret of the Clinic staff, Dr. W. Johnston retired during the year, having accepted an offer to take charge of a Children's Unit in his native Scotland. It is particularly unfortunate that the vacancy created 14 months previously, by Dr. Sime's departure, has not been filled, and that there is delay in appointing Dr. Johnston's successor. Continuity of treatment is essential in order to provide a satisfactory Child Guidance Service. In consequence the remaining staff are working under difficulty.

"They hope that another Consultant in Child Psychiatry will be appointed as soon as possible, and that the interests of the Child Guidance Clinic will be considered when such an appointment is made.

"The staff were sorry to lose Miss Rossall, and she is much missed. She has not been replaced as yet. Mr. F. Wyatt was welcomed, during the year, as educational psychologist."

Dr. Wardle reports:

"It will be noted that the number of referrals to the Clinic fell to 99 compared to 130 in 1965. This fall seems entirely attributable to fewer referrals from School Medical Officers as the referrals from General Practitioners increased. It has been possible to treat a much larger number of children with play therapy and psychotherapy than in the past because of the use of group techniques. This has enabled us to treat up to eight children at a time with considerable success.

In September 1965, a pilot in-patient unit for children was started at the Exe Vale Hospital, Wonford. This has enabled us to investigate and treat severely disturbed children and adolescents. Only eight beds were available so we have limited the admission of patients to those between the age of 11 and 14. Work has now started on a larger unit which will cater for 17 in-patients and 10 day patients. The unit will incorporate a small school for maladjusted children and will provide all the facilities for treatment and care of severely disturbed children between the ages of 7 and 15. Work is expected to be completed on the buildings by April 1967 and progress towards full use will then depend on the recruitment and training of a suitable staff. The type of child we have treated successfully in our pilot unit has varied from the severe childhood schizophrenia to aggressive anti-social behaviour of children from very disturbed home backgrounds. We have had particular success with disturbed adolescent girls and children with school phobia. Hitherto, many of these children would have had to be dealt with by the Courts because they could not be contained in the community.

"In addition to the in-patient facilities already mentioned, we are now establishing 6 beds for adolescents between the age of 15 and 17. These beds will be for neurotic and borderline psychotic adolescents. We will be unable to cater for the severe delinquent or psychopathic patient.

"It has become evident that there is a need for out-patient Clinics for adolescents outside school and working hours. An adolescent Clinic is, therefore, to be started at the Royal Devon and Exeter Hospital on Thursday evenings from 5.30–7.30 p.m.

"In our work we have noted the need for small special classes for children of average intelligence whose emotional disturbance or behaviour makes it difficult to manage them in the large classes of ordinary schools. At present these children are either disrupting the classes they are in or are failing to thrive educationally or at great cost to the community are being sent to boarding schools. Boarding school placement is essential in cases where the home life is causing or aggravating maladjustment but in those cases where the home is a happy one and the problem lies in the child's adjustment to school, a small class or group of classes with specially trained teachers can solve the problem without the unhappiness or expense of removing a child from home."

Number of pupils treated at child guidance clinics under arrangements made by the authority	1,050
Total Number being treated 1st January, 1966	500
Residential	38
Number on waiting list 1st January, 1966	60
Number referred during 1966	452
Number discharged during 1966	443
Number being treated 31st December, 1966	514
Residential	33
Number on waiting list 31st December, 1966	60

Educational Psychologists

There are six educational psychologists including the senior, Mr. P. C. Love who work closely with the school medical officers. Where it is necessary to complete form 2 H.P. the educational psychologist completes the first part and the medical officer the remainder, the examination including an audiogram. The final recommendation is made by the senior school medical officer, after consultation with the senior psychologist, an arrangement which is working smoothly.

HEARING ASSESSMENT CLINICS

Four of the school medical officers have received special training in the assessment of deaf children and four hearing assessment clinics have been established to date for North Devon, East Devon, the Torbay area, and West Devon. Some children from the south and west are referred to Plymouth hearing assessment clinic.

All children receive an annual hearing test in school and those in whom there is reason to doubt aural acuity including pre-school children, are referred to the hearing clinic run by these school medical officers. If found to be deaf they are passed to the hearing assessment clinic at which an E.N.T. consultant attends as well as the medical officer and other interested workers, e.g. peripatetic teacher for the partially hearing, audiometrician, speech therapist, health visitor. A decision is made there as to the best medical treatment and education for the child.

East Devon Area

Dr. Archer reports:

"Attendances at the East Devon Hearing Assessment Clinics are given in the table. Of the 82 new patients, 46 were found to have normal hearing. Ten

of these children were referred for speech therapy. Thirty-one of the new patients are still under investigation, or attending for review, or awaiting removal of tonsils and/or adenoids. Four children were prescribed hearing aids during the year; three of these have severe bilateral hearing loss and belong to families in which an older child is already under treatment for severe nerve deafness. This re-emphasises the point made in my last report that familial nerve deafness is numerically the most important aetiological group among our patients with hearing loss at hearing aid level.

"The new Exeter City Audiology Unit became avilable for clinics in May. It was a most interesting and instructive experience to re-test in acoustically-prepared conditions children who had previously been tested repeatedly under classroom or ordinary clinic conditions. Babies and young handicapped children are so much easier to test and a constant and repeatable level of response is much easier to obtain from them in a room where reverberation of sound is reduced. A small group of older children, who had consistently shown a slight or moderate loss of pure tone hearing in threshold audiometry, but normal hearing for speech when tested under ordinary acoustic conditions, showed a hearing loss for speech commensurate with their pure tone thresholds when tested in the Audiology Unit. This observation suggests that these children use refracted sound to aid their speech discrimination. It demonstrates the value of acoustically treated testing rooms in making a full and accurate clinical investigation but underlines, too, the importance of taking account of the patient's performance under the ordinary conditions of life when considering treatment. In sound-absorbent rooms some of these children presented a picture of hearing loss for speech and pure tone at hearing aid level. In every day conditions of free field hearing they function normally and a hearing aid might well be a positive disadvantage to them.

"It is a very great advance to have an audiology clinic in which to investigate and review our patients, but in considering treatment, both medical and educational, we must continue to study them in their homes and in their schools under conditions of every-day hearing if their individual needs are to be understood."

EAST DEVON HEARING ASSESSMENT CLINICS, 1966

	Attendances	New Patients	Normal Hearing	Review	Aids Prescribed
Consultants' Clinic					
Exeter	29	22	15	6	1
Hearing Assessment					
Medical Officer's Clinics					
Exeter	71	37	18	17	1
Exmouth	46	23	13	8	2
TOTALS	146	82	46	31	4

Tavistock/Holsworthy Area

Dr. M. E. Budding, the medical officer in charge of the Tavistock/Holsworthy area hearing assessment clinic, reports:

Hearing Assessment Clinics

"The main difficulty has been in arranging for joint sessions with the E.N.T. Consultant, as he kindly comes at his only available time, i.e., lunch

time at Holsworthy and early evening in Tavistock. The latter arrangement is not very suitable for infants, but on the other hand suits some parents of school-age children as the fathers can either provide transport or baby-sit at home! Transport is the biggest problem perhaps.

Tavistock H.A.C. 1966—10 Sessions

Number referred for investigation—1966:	18
	1 pre-school
	17 School
Number of old cases seen—1966:	11
	4 pre-School
	7 School
Total number of children seen—1966:	29
	5 pre-School
	24 School

New cases referred by:

A.C.M.O.	15
G.P.	2
H.V.	1

No. of cases attended at H.A.C.:

No further action needed	5
Left area	2
Referred to Joint H.A.C.	5
Referred to E.N.T. Surgeon	2
Under Observation	15

Joint H.A.C.:

Old cases using hearing aids	6 (1 pre-school, 5 school)
New cases advised hearing aids	2 (1 pre-school, 1 school)
Further observation	2

Of the 8 children using aids, 6 suffer from nerve deafness and 2 from conductive.

Holsworthy H.A.C.—1966 (9 Sessions)

Number referred for investigation—1966:	7
	1 pre-School
	6 school
Number of old cases seen:	8
	2 pre-school
	6 school
Total number of children seen in 1966:	15
	3 pre-school
	12 school

Cases referred by:

A.C.M.O.	6
H.V.	1

No. of cases attended at H.A.C.:

Referred to E.N.T. Surgeon	2
Referred to Joint H.A.C.	2
Under observation	9
Discharged	2

Joint H.A.C.:

Using hearing aid	1
No further action	1

The boy using aid suffers from nerve deafness.

It is a great advantage to have the services of the Welfare Officer for the Deaf, with whom the team has had meetings, to discuss (*a*) School Leavers, in good time before they leave, and (*b*) "problem families", using hearing aids."

North Devon Area

Dr. M. J. Dunn, medical officer in charge of the North Devon Hearing Assessment Clinic, reports:

"In North Devon, Hearing Assessment Clinics are held every Tuesday morning. At Bideford on the first, Ilfracombe on the second and Barnstaple on the third Tuesdays of each month, the fourth Tuesday being divided between South Molton and Tiverton alternatively. Cases attending Barnstaple, Bideford, Ilfracombe and South Molton clinics can be referred to consultant sessions held fortnightly at the North Devon Infirmary, where they are seen by Mr. Lloyd-Davies and these sessions are attended by the whole hearing assessment team. For the Tiverton cases this service is not available and each case requiring consultant opinion is referred individually to Mr. T. Bradbeer at Exeter by personal letter.

"During 1966 a change was brought about in the consultant sessions. Previous to April these has been held monthly on the fourth Wednesday afternoon and were specifically hearing assessment clinics, in April this was changed to seeing a few cases only on Friday afternoons at Mr. Lloyd-Davies' routine E.N.T. outpatients'. It was found adequate to meet twice a month on the second and fourth Fridays and, as previously, the whole hearing assessment team are present.

"During 1966 the number of sessions and cases for each clinic was as follows:

Bideford	—8 sessions	—40 cases
Ilfracombe	—9 sessions	—33 cases
Barnstaple	—9 sessions	—52 cases
South Molton	—4 sessions	—24 cases
Tiverton	—5 sessions	—23 cases

14 cases were dealt with at the consultant clinics.
It is felt that the work done by the hearing assessment team in North Devon is producing good practical results and I enjoy the maximum of co-operation from fellow members of the team, for which I am most grateful.

"There are, in all, 56 children in my area (excluding Tiverton) who have been provided with hearing aids and both the peripatetic teacher and audiometrician are doing excellent work in following up and supervising all cases where this is required."

Torbay Area

The Medical Officer in charge of the Torbay Hearing Assessment Clinic,

Dr. L. Solomon, reports:

"Those of us who are engaged in preventive health work are often compared with door-to-door salesmen. We have to try to get a "foot in the door" and then persuade the parent that their child is not in perfect health and that the defect can interfere with educational progress. This applies particularly to hearing defects because few parents like to admit that their child is hard of hearing. It is so much easier for them to rationalise it as a lack of attention, daydreaming, or even naughtiness. The wearing of a hearing aid when prescribed is often resented more by the parent than by the child. We often get over this by suggesting that the hearing aid is worn only in school. This is almost a repetition of what happened when spectacles were first prescribed for school-children many years ago and we hope that in the not too distant future the wearing of hearing aids will be accepted as readily as spectacles are today.

"Annual word tests continue to produce a selection of children in all age groups whose hearing has become defective since the previous year's test. These are confirmed by audiogram and referred to the Hearing Assessment Clinic. Reports on all children seen, and even on defaulters, have always been sent to the family doctor as well as to the school medical officer. I am told that these reports are appreciated and have encouraged more family doctors than ever to refer children for assessment. In fact the general practitioners referred nearly as many cases as did the consultants and each referred more than did the health visitor or school nurse in the past year.

"The number of pre-school children referred continues to grow and was nearly one quarter of all those referred. These invariably take much more time and patience and many more sessions to test. The close team-work of the Audiometrician and Hearing Assessment Medical Officer had evolved a routine which worked very well and gave remarkably accurate results.

"Evaluation of results and testing standards is always important. During 1966 fourteen children started school who had been referred by health visitors and others as having failed the under five hearing tests in previous years. These children had all been seen at the Hearing Clinic and after detailed testing found to have socially adequate hearing at that stage. On school entry this year these were all followed up by pure tone audiometry. One is pleased to say that in only one case out of fourteen did the accurate pure tone audiogram show that the child's hearing was just below the limits of normality. All the others were well within normal limits. The other children in whom hearing defects were diagnosed in infancy and were not remediable still had their hearing defects (as shown by audiogram) when they started school. Operations or treatment in the other cases alleviated the deafness and so made school work and learning less frustrating than it might have been.

"Each year a meeting of all health visitors and school nurses in the hearing assessment area is called to discuss problems of testing, of techniques, of co-operation and of timing. Variations from one area to another are inevitable but it is surprising how much one learns in discussion and from listening to other people's arguments and problems.

"Doubts are continually being cast on the necessity for annual hearing tests, though annual vision tests are accepted as valuable. The suggestion is that one sweep test at five or six years of age would bring to light any hearing defect, and the Entrant medical inspection will pinpoint the child who needs to be watched for possible hearing defects. This is just not true. The commonest cause of hearing defects found is catarrhal or conductive type of deafness due to infection. This does not usually produce a profound type of deafness, but the hearing defect is often sufficient to interfere with schooling and to be the

cause of inattention, scholastic retardation, frustration and psychological disturbance in the child. One has to be constantly on the look out for defects which indicate that the child is not in an optimum state of health. In the schools for which I am responsible not only were six new cases of hearing defect discovered in the year (in the age group 5, 6, 7, 9, 10 and 12) but many of the other twenty-nine known cases showed deterioration in their hearing which necessitated reopening investigation or more frequent follow up than was originally anticipated.

"In comparison to these thirty-five children who failed word tests, forty-two children failed the vision test and were referred to the ophthalmologist. These also were in the age groups 5, 6, 7, 8, 9, 10 and 11 years. In neither case would vision and hearing tests at one specific age group have picked up more than a very small proportion of the cases.

"One has never understood the statements made by Johnson (1960) and Newby (1959) that between 4 and 5 per cent of the school population have medically significant hearing losses. An analysis of the results of detailed testing of children in this area over the past five years showed that in any one year only between 2.4 and 1.6 per cent failed the word test and were referred to hearing clinics and of these between 0.7 and 0.4 per cent were completely new cases found in that year. One can only assume from this that there are regional differences in the number of children who have medically significant hearing losses or that the above mentioned authors have painted a blacker picture than actually exists. National surveys are needed and specialised research is indicated in this field.

"The Audiology Clinic has had to rely on one pure tone portable audiometer and other home-made equipment to do all the testing of school and pre-school children in the area. Although Professor Ewing and Professor Ian Taylor and others had recommended other essential equipment for hearing clinics and this had been requested, none had been purchased for our use up to date. If it were not for the generosity of the Goodrington Townswomen's Guild in donating a sound level meter for use in testing Torbay children we would be without even this valuable piece of apparatus considered so essential by Professor Ewing and others. It is not just sufficient to diagnose a child as having a hearing defect it is nowadays necessary to try and ascertain the location and type of lesion and to exclude psychological and other causes. There are tests for this but they need instruments and specialised apparatus. We have made a start in a small way with a borrowed tape recorder to do speech discrimination tests. After all one does not speak in "pure tones" but in "phonemes", syllables, words or sentences. The intelligible understanding of words and speech is therefore a greater guide to social and educational inadequacy than is a test for pure tones only. Each has its place in giving an over-all picture of the child's capacity for understanding speech, and being able to communicate with others.

"Advisory work continued to be our main concern and useful work was done at the Week-end Conference for Parents of Partially Hearing Children in Primary Schools held at Dartington Hall. This year the hearing assessment medical officers made a contribution and emphasis was placed on the future prospects and work capabilities of these children.

The parents were most appreciative that so many people were concerned with their children's future and the work of the after-care services of the welfare worker was explained to them.

The attached list gives details only of the new cases seen in the year, but many more cases were seen for review from previous years. It should also be noted that in the Hospital Clinic all children wearing hearing aids were seen at least once in the year and many other children were seen for review."

EIGHTH YEAR OF SOUTH DEVON HEARING ASSESSMENT SCHEME (1966)
(New Cases only)

(1) School population of area			24,000	
Pre-School population of area			12,000	
(2) Number of children referred for investigation in 1966				120(School 88 (Pre-School 32
(3) Children were referred by:—				
A.C.M.O. ..	(11 Pre-School) ..		63	
H.V./S.N. ..	(6 Pre-School) ..		15	
Consultant ..	(12 Pre-School) ..		19	
G.P.	(2 Pre-School) ..		15	
Parent	(0 Pre-School) ..		2	
Other H.A.C. ..	(1 Pre-School) ..		6	120
(4) Children referred to Hearing Clinic:—				
No further action needed			33	
For re-check			66	
Hearing Assessment Clinic			15	
Refused			2	
Left area			4	
Not seen yet			2	
			—	120
Number of Sessions	88	(School	57	
		(Pre-School	31	
Total number of	229	(School	164	
Examinations		(Pre-School	65	
Appointments not kept	111	(School	90	
		(Pre-School	21	
(7) **Hospital Assessment Clinic:—**				
No further action		.. ..	2	
Advised operative treatment		.. ..	2	
Advised hearing aid		.. ..	7	
Further observation		.. ..	2	
			—	13
Number of Sessions	36	(School	17	
		(Pre-School	19	
Total number of	206	(School	176	
Examinations		(Pre-School	30	
Appointments not kept	47	(School	43	
		(Pre-School	4	

Word tests results. All children tested by School Nurse in Dr. Solomon's Schools. (Except P.H.U. children.)

	School population	*Failed Test*	%	*Completely new cases*	%
1962	4395	100	2.32	34	0.7
1963	3259	78	2.4	25	0.7
1964	3243	63	2.0	18	0.5
1965	2094	47	2.2	8	0.4
1966	2295	38	1.7	9	0.4

AUDIOMETRY

Work in the field of hearing and speech increases every year. This service includes three essential parts:

1. Screening in appropriate age groups to demonstrate normal hearing and language development.
2. Investigating children who fail these screening tests.
3. Treating the children shown by investigation to be defective in hearing or speech.

Hearing tests for infants are carried out routinely according to the methods recommended by Manchester University by health visitors before the first birthday. There is close supervision and testing of all babies known to be at risk. Health visitors also carry out vocabulary tests for hearing when a child enters school and subsequently each year. Any child suspected of a degree of

deafness is referred to the hearing clinic and an audiogram is requested by the medical officer. The audiometricians have also carried out a number of sweep tests in schools throughout the area. They attend at hearing assessment clinics and do a great deal of work in the testing and care of hearing aids.

Audiometricians' Report

Total number of audiograms	3,413
Number of children "Sweep" Tested	3,499
Number of hearing aids issued (all areas)	50
Hearing aids tested	197
Sent for repair	104

The county paid for 15 commercial A.V.C. Hearing Aids for special cases during the year. These are supplied on the recommendation of the E.N.T. consultant, usually for cases of high frequency deafness.

SPEECH THERAPY

During 1966 we have been fortunate in obtaining the services of several speech therapists on a part-time basis. In spite of this, in a few parts of the county a speech therapy service cannot be offered.

All children are seen by a medical officer for a medical examination which includes an audiogram prior to his recommending treatment.

In another area, a speech therapist has been working for one session a week at the Countess Wear Clinic run by the Spastics Society for cerebral palsied children.

At Tiverton and Honiton groups of pre-school children with speech difficulties meet at the clinic; this is proving most successful. The need for handicapped children to mix with others in the pre-school years is being found by speech therapists as well as workers in other disciplines.

Three speech therapists are also employed part-time by the Regional Hospital Board to treat adults. This work is particularly interesting and rewarding to the therapists but has to be restricted to one session per week because of the demand of the school health service.

During the year three Day Conferences were held in Exeter for Devon speech therapists. These included lectures, discussions and films.

Statistics relating to work in the different areas are given below:

Area and Officer	No. of clinics operating	Cases discharged during year	Under treatment at end of year	Under observation	Awaiting treatment	Totals
E. Devon	18	92	105	52	45	312
W. Devon	16	109	119	42	83	369
N. Devon	9	57	75	15	52	208
S. Devon	9	35	83	57	27	211
Totals	52	293	382	166	207	1100

Speech Therapy Clinics—Annual Returns of Work for 1966

Speech Therapy—Diagnostic Categories of Cases—treatment completed

Delayed Speech	93
Cleft Palate	5
Cerebral Palsy	4
Articulation Defects	132
Dysphonia	3
Hearing loss	7
Stammer	36
Others	13
	293

SCHOOL OPHTHALMIC SERVICE

Every child received an annual vision test in school and those whose acuity was less than 6/9 in one or both eyes were referred to one of our four part-time ophthalmic specialists.

The geography of the county and availability of suitable clinic space have, between them, dictated the development of the school ophthalmic service as one primarily operated in schools rather than clinics.

Few schools have suitable facilities for this work, and with the development of Health Centres these will be used, subject always to the convenience of schools and parents and to facility of attendance.

The difficulty of arranging transport to the clinics is becoming more acute in some rural areas and it may be necessary to arrange our own transport system to ensure that children do not default from their appointments.

Dr. Barnett, Ophthalmologist for West Devon, reports:

"The illuminited test types now available at Okehampton and Tavistock are very much appreciated, and I look forward to having the same equipment at Holsworthy in due course.

"The Hospital Car Service should help us to combat the absentee problem and every care is being taken to avoid any unnecessary use of this service."

Dr. McCormick, Ophthalmologist for South Devon, reports:

"The number of patients to be seen is always on the increase, due to constant population influx into Devon and to the opening of new schools. By increasing the use of the well-equipped Clinics in this area and reducing the visits to schools, where the facilities for eye examination are frequently poor and often non-existent, the waiting time for an appointment for new cases is never normally more than six weeks."

Eye Diseases, Defective Vision and Squint

	Number of cases dealt with
External and other, excluding errors of refraction and squint	2,739
Errors of refraction (including squint)	8,838
Total	11,577
Number of pupils for whom spectacles were prescribed	4,075
Total number of sessions held at schools ..	322
Total number of sessions held at clinics ..	467
Total number of school children seen ..	9,092
Total number of pre-school children seen ..	3,573

Ten Year Record of above Table

	Number of cases dealt with	*Number prescribed glasses*
1957	12,108	3,180
1958	11,261	2,269
1959	9,225	2,861
1960	9,890	1,771
1961	11,071	2,072
1962	11,063	1,179
1963	10,648	3,101
1964	11,575	3,434
1965	11,321	3,858
1966	11,577	4,079

HANDICAPPED CHILDREN

The introduction of developmental clinics (reported elsewhere) should ensure the early detection of handicaps, and is a most desirable innovation.

In many cases, before ascertainment can be made, many opinions must be sought from workers specialising in one aspect of the problem of handicapped pupils, e.g. G.P., paediatrician, speech therapist, peripatetic teacher of partially hearing, educational psychologist, etc. The medical officer having received these opinions must co-ordinate them and assess the child as a whole, before making his recommendations to the parent and the education authority. Even in cases where formal ascertainment is no longer required (e.g. prior to admission to day-schools for the E.S.N.) it is still the duty of the school medical officer to assess the child comprehensively. Without this careful evaluation mistakes in diagnosis and placement will occur.

Handicapped children may not leave special schools until they are 16 years old, but a scheme for continued care up to 18 years is being developed. The education authority's residential special schools have for some time been implementing schemes for ensuring appropriate placement and follow-up, teachers being especially allocated time for this work. This type of work is also carried out by the social workers in mental health in appropriate cases.

One medical officer reports:

"As developmental assessment in the Child Welfare Clinics becomes more general and more precise, we shall be increasingly aware of, at least, some of the

children who will require special methods of learning and teaching, well before they reach the present age of school entrance. If they are to fulfil their educational potential, thinking, experiment and planning are needed concerning the pre-school and the earliest school years of these children, who are now tried in the ordinary school for several vital years, found unable to benefit and then ascertained as educationally subnormal. Experiment in special provision for these children within the framework of future planning for Nursery School and Primary School education is surely a challenging and exciting possibility which could radically alter our approach to the education of the "educationally subnormal' child."

During 1966 the school health sub-committee have agreed to the payment for the attendance and transport of children to privately-run day nurseries, where the child is handicapped and in need of the stimulus of mixing with normal children. This arrangement has been extremely rewarding to the children concerned, especially children handicapped by a degree of deafness or mal-adjustment.

In a country area such as Devon, transport difficulties have in some cases prevented attendance where this would have undoubtedly benefitted a child. It is unfortunate that Devon does not have and is unable to provide day nurseries in the main centres of population, not only for handicapped children, but also for the normal child who benefits enormously from mixing with his peers before attending school formally at the age of five.

Circular 9/66: Co-ordination of Education, Welfare and Health Services for Handicapped Children and Young People

This circular required local authorities to consider means in which improvements could be made in co-ordination. The type of difficulty met is exemplified in one medical officer's report:

"The number of people and departments concerned with and visiting these families seems to be continually increasing and must be very bewildering for the parents. It seems to me that a great deal of time and energy would be saved and a great deal more accomplished if there was more liaison between the various departments concerned, as several people seem to be doing different things at the same time quite independently and in complete ignorance of each other's efforts."

The Chief Officers of the Children, Education, Welfare, and Health departments met on several occasions to consider means of improving co-ordination, and produced the following recommendations:

1. Much work for handicapped children is being done at present but there is a need for extension of this work and better co-ordination between departments concerned.

2. As the Youth Employment Officer is not employed by the Education Authority, close co-operation is essential. This might be achieved by the appointment of a specialist Youth Employment Officer covering a wide area with specific responsibility for special schools, handicapped children, and children with handicaps in normal schools. The local Youth Employment Officer would refer to him any cases requiring his special attention. Ways should be considered of referring children to the Youth Employment Officer at an earlier age in normal schools.

3. Every effort must be made to discover and ascertain handicaps as early as possible.
4. Children attending residential special schools should be reviewed annually by the Senior Medical Officer for Child Health and the Senior Educational Psychologist. Up to date Health Visitor, School Medical Officer, P.S.W., Psychologist and school reports should be avilable for the meeting.

   In the case of maladjusted children, the Psychiatric Social Worker from the Clinic which originally referred the child should visit during all holiday periods.
5. As far as possible, only one person should be visiting handicapped children at one time. This person should not make decisions which are the responsibility of other departments, and where any problem arose a meeting of representatives of all the services concerned should be called to decide who should take major responsibility.
6. Multiplicity of visiting pre-school children should as far as possible be avoided, but where multiplicity of handicaps make it necessary the P.S.M.O. should co-ordinate.
7. A careful review of handicapped school leavers should be made in the penultimate year before the child is due to leave school. Should the services of the Welfare Department be seen to be required in the future, this is the time when they should be called in.
8. Follow-up of educationally subnormal children is not yet sufficiently comprehensive. Cases of difficulty in respect of children who have left the school, for employment or otherwise, should be referred to the County Medical Officer. Difficulties in respect of physically handicapped children should be referred to the County Welfare Officer.
9. Hostels or lodgings for educationally subnormal children may be required in order that the young people may live in an area with suitable employment. The P.S.M.O. will look into this question and assess the need.

Deaf School Leavers

With the appointment of a welfare officer for the deaf working from the welfare department, an effort was made to improve co-ordination between the school health and the welfare care of deaf and partially hearing school leavers. The welfare officer of the deaf was invited to attend meetings of all workers concerned in the care of deaf children during the last year of the pupil's attendance at school, so that she would be aware of any special problem and would pave the way for good care of the handicapped school leaver.

This arrangement has worked well.

Development Clinic in Barnstaple

Dr. Hall, acting medical officer, reports:

"The Development and Advice Clinic has continued at the Infant Welfare Clinic, Barnstaple during the year 1.4.66–31.3.67 with very good attendance, and appointments are at present three months ahead.

"All children have been referred by their General Practitioners, the majority being under school age, presenting problems in development or abnormal birth histories. It is therefore possible for handicaps to be found and mental retardation diagnosed at an early age, so that the parents can be given advice and guidance regarding future management.

"Each child attends the clinic three times for close observation and developmental examinations. A full report is sent after every visit to the family doctor for his opinion.

Total number of children attending from 1.4.66–31.3.67 .. 53
Girls .. 20
Boys .. 33

Total number of visits:

	Girls	*Boys*
First visit	13	23
Second visit	12	18
Third visit	4	9
	29	50

GIRLS

12—Normal level of intelligence	2 slow in talking
	1 Neuromyopathy
	5 'At Risk'
	1 Chronic ill health
	2 slow motor development
	1 socially deprived
1—Low Average Intelligence	(Malnutrition)
2—Subnormal	1 Mild Spastic
	1 slow mental development
5—Severely Subnormal	2 Physically handicapped
	2 Spastic
	1 Mongol

BOYS

15—Normal level of intelligence	4 Slow motor development
	4 'At Risk'
	1 partially deaf
	4 slow in talking
	1 socially deprived
	1 short sighted
11—Low average intelligence	6 slow mental development
	1 At Risk
	2 slow in talking
	1 partially deaf
	1 partially sighted
6—Subnormal	4 slow mental development
	1 severely deaf
	1 slow development especially speech
1—Severly subnormal	Brain damage

Handicapped Register

A register of handicapped children is kept in the central office and is compiled from reports sent in by medical officers, health visitors and others. A card is made out and sent to the medical officer of the area in which the child lives, a duplicate card is retained so that before the child is due to start school notice may be sent to the medical officer concerned, to enquire whether special educational provision will be necessary if not already in hand, the whole purpose of a register being to ensure appropriate and continuing care for each child,

The numbers of handicapped children registered in the department at 31st December, 1966, were 1,084 children of school age and 339 aged two to five years. They fall into the following categories:

	5-to-16	2-to-5
Blind	14	2
Partially Sighted	14	15
Deaf	16	3
Partially Hearing	50	11
Epileptic	8	24
Delicate	94	70
Physically Handicapped	110	117
Educationally Subnormal	431	—
Maladjusted	54	—
Mentally Handicapped (unsuitable for education at school)		
Subnormal	238	97
Severely Subnormal	55	—

Partially Hearing Children

The great majority of hearing aid wearers manage very well in ordinary school with help from the peripatetic teacher of the partially hearing.

There are units for 8 partially hearing children each, attached to a primary and a secondary school in Torquay.

Many visitors have seen over these units at Westhill County Secondary School and St. Margaret's County Primary School.

Week-end Residential Course for Parents of Partially Hearing Children

In October, 1966, a course for the parents of primary school partially hearing children was held at Dartington Hall. This course was organised by the education department in consultation with the school health service and proved very successful. The parents lived at Dartington Hall over the week-end and were able to discuss problems informally with members of the staff of both the education department and school health service, and had an opportunity to meet each other.

Delicate and Physically Handicapped Children

Steps Cross School at Torquay, a day school of 90 places, has its full complement of physically handicapped pupils, and since an orderly has been appointed it has been possible to take chair cases, and other children needing more personal attention than previously. Several muscular dystrophy cases and partially incontinent children have now been admitted whereas previously only home tuition was available to them. Children with asthma or bronchiectasis constitute the majority of the pupils, and regular daily physiotherapy has improved or maintained their health so that regular school attendance has been possible.

The teachers, the meals staff, the physiotherapist, the remedial occupational therapist, the taxi drivers and the pupils have such a close community spirit, inside and outside the school, that the well-being and educational progress of the child is their main concern. The full ordinary school curriculum is taught and a high proportion of children are selected for grammar school places.

The Medical Officer reports:

"The number of children registered at the school varies from year to year—some leave school, some improve in health and go back to ordinary school, and

unfortunately, some deteriorate and can no longer attend school. With the help of the Orderly we have been able to retain children in school this year who would normally have been too ill or too immobile to come to school. Our aim has always been to keep the children in the community as long as possible, in contact with their friends, and not to isolate them at home.

Physiotherapy has played a large part is helping the asthmatic and bronchitic child overcome his disability and often to do without emergency medication. So many children use inhalers when they first come to Steps Cross School but after a term or two the use of the inhaler is less frequent. This is indeed a good thing because concern has been expressed in medical journals about the indiscriminate use of inhalers by children. Swimming as a breathing exercise has also helped many children.

It is difficult to measure the exact improvement in lung capacity produced by regular breathing exercises and swimming. It was possible to borrow a Wrights Peak Flow Meter once a term and the resultant graphs have given encouragement to the children and have proved to the parents how much better the children have become."

Many children with physical handicaps cope in the ordinary schools or training centres available to others of comparable intelligence. Some children are remarkable in the way they overcome severe handicaps. Dame Hannah Rogers' School at Ivybridge caters for severely cerebral palsied children of average or E.S.N. intelligence; this is an independent boarding and day school which many Devon children attend.

Educationally Subnormal Children

There are four schools in the county for these children:

Maristow, near Plymouth (residential)	89 pupils (Girls)
Bradfield School, Willand (residential)	75 pupils (Boys)
Withycombe House School, Exmouth (residential)	45 pupils (Girls)
Combe Pafford School, Torquay (day)	125 pupils (Boys & Girls)

One of my medical officer's reports:

Coombe Pafford Day School for E.S.N. Children has filled a long-felt want in this area even though children are not admitted till they are over seven years What is needed is an observation class for five to seven-year-olds where educationalists and doctors can observe children under school conditions and assess their suitability for the education most appropriate to their degree of retardation.

Southbrook School, Exeter, will open in April, 1967, offering day places to Devon children.

There are also five full-time special classes in ordinary schools, and many part-time classes held by the peripatetic remedial teachers.

At all of the special schools a member of staff has special responsibility for job placement and follow-up of the children, and the results are most encouraging.

Epileptic Children

Epileptic children are in the main contained within normal schools. A few are at special schools for epileptic children, but, as medical control of this disability has advanced, it becomes increasingly possible to integrate the epileptic child into the normal school community.

Maladjusted Children

Maladjusted children can be received into Crichel hostel at Totnes or The Gables at Willand. Those who are unsuitable for either, insofar as they are too disturbed to go out daily from the hostels to normal schools, are placed in residential special schools.

Special Schools

During 1966 Handicapped children from Devon have been placed in the following special schools:

PHYSICALLY HANDICAPPED
*Steps Cross Special Day School, Torquay

EDUCATIONALLY SUBNORMAL
*Maristow House School, Roborough
*Withycombe House School, Exmouth
*Bradfield School, Willand

BLIND AND PARTIALLY SIGHTED
Royal School of Industry for the Blind, Bristol
Dorton House, Sevenoaks, Kent
Condover Hall, Shrewsbury, Salop.
Sunshine House School, Northwood, Middlesex
West of England School for the Partially Sighted, Exeter, Devon

DEAF AND PARTIALLY DEAF
Royal West of England Residential School for the Deaf, Exeter, Devon
Hartley House School for the Deaf, Plymouth, Devon
Mary Hare Grammar School for the Deaf, Newbury, Bucks.

EPILEPTICS
Lingfield Hospital School, Surrey

DELICATE AND PHYSICALLY HANDICAPPED
Heathercombe Brake School, Manaton, Devon
Heathlands Rise School, Teignmouth, Devon
Victoria Home and School, Poole, Dorset
St. John's Open Air School, Woodford, Essex
Coney Hill Home School, Kent
Halliwick School, Bush Hill Road, Winchmore Hill, London

SPASTICS
Trengweath School and Centre for Spastics, Plymouth
Dame Hannah Rogers School for Spastics, Ivybridge, Devon
Chailey Heritage Craft School & Hospital, Sussex

* Devon County L.E.A. School.

IMPROVEMENTS TO SCHOOL PREMISES

Lastly, but by no means least, is appended a list of improvements to school premises during the year. Devon is a rural area with many small schools. The condition of lavatories in many primary schools remains unsatisfactory in spite of valiant efforts by caretakers; and seems worthy of a higher priority for improvement than given to it at present.

Improvements to Sanitary Accommodation, etc., Minor Improvements

Primary Schools

School	*Improvements*
Offwell C. of E.	Improvements to heating.
Halwill C.P.	Supplementary electric heating.

Dartmouth C.P.	Hot water supply to girls' toilets.
Branscombe Primary	Improvements to heating.
South Tawton C.P.	Improvement to heating in Infants' classroom.
Berry Pomeroy Parochial	Additional heating.
Bradford C.P.	Additional heating in Infants' classroom.
Wembury C.P. (Old School)	Hot water supply.
Ashburton C.P.	Improvements to old clinic room.
Bishopsteignton C.P.	Socket outlet for Dental Unit.
Abbotskerswell C.P.	Fluorescent lighting.
Bovey Tracey C.P.	Fluorescent lighting in Hall.
	Frost proofing of toilets.
Bow C.P.	Improvement to heating in Infants' classroom.
Broadwoodwidger C.P.	Lower ceiling of M.I. room.
Buckfastleigh C.P.	Hot water supply to men's washbasin.
Broadhempston C.P.	Renew urinal and repair floor.
Cheriton Fitzpaine C.P.	Renew urinal and repair floor.
	Frost precautions to Girls' toilets.
Clawton C.P.	Electric and water points for Dental Unit.
Cockwood C.P.	Renew urinal.
Copplestone C.P.	Renew urinal.
Cullompton C.P.	Renew two urinals.
Denbury C.P.	Extend roof of toilet block.
Doddiscombsleigh C.P.	2 drinking fountains.
Honiton C.P.	Renew 3 urinals.
Ide C.P.	Hot water supply to basins.
Ipplepen C.P.	Improvements to sanitary accommodation, W.C.'s, basins and urinals.
Moretonhampstead C.P.	Fluorescent lighting for 2 classrooms.
Newton Abbot Decoy C.P.	Drinking fountain.
Newton Poppleford C.P.	Fluorescent lighting.
North Tawton C.P.	Enclose toilets.
Ottery St. Mary Infants'	Improvements to heating.
Ottery St. Mary Girls'	Improvement to lighting.
Sandford C.P.	Renew urinal.
Shaldon C.P.	Renew urinal.
Shillingford and Petton C.P.	Electric socket for Dental Unit.
Shute C.P.	Renew urinal.
Sidmouth Infants	Additional toilet.
Tedburn St. Mary	Renew urinal.
	Hot water supply to Infants' classrooms.
Throwleigh C.P.	Renew urinal.
Tiverton, Bampton St.	Renew urinal.
Uffculme C.P.	Provide M.I. room.
Ugborough C.P.	Improvements to lighting.
Upottery C.P.	Alterations to main water supply.
West Putford C.P.	Frost proof boys' lavatories.
Whimple C.P.	Renew W.C. pans.
Widecombe-in-the-Moor C.P.	Drinking fountains.
Awliscombe V.P.	Renew urinal.
Blackpool C. of E.	3 new washbasins.
Dartington C. of E.	Enclose girls' lavatories.

Exbourne C. of E.	Oil-filled electric radiator for Infants' room.
Halberton C. of E.	Renew urinal.
Kenn C. of E.	Sink in M.I. room.
Kilmington V.P.	Renew urinal.
Landscove C. of E.	Renew urinals.
Newton Abbot Marsh C. of E.	Repairs and renewals in lavatories.
Offwell V.P.	Widen gates for Dental Unit.
Otterton V.P.	Renew urinals.
Payhembury C. of E.	Renew urinals.
Plymtree C. of E.	Frost proof toilets.
Sidbury C. of E.	Frost proof toilets and renew urinals.
Tipton St. John	Drinking fountain.
Woodbury Salterton C. of E.	Widen entrance for Dental Unit. Electricity and water outlets for Dental Unit.
East Allington C.P.	Improvements to lavatories.
Gulworthy C.P.	Frost proof toilets and renew urinal.
Huccombe C.P.	Drinking fountain.
Ivybridge C.P.	Frost proof toilets and renew urinal. Hot water to wash basins.
Loddiswell C.P.	Renew urinals. Hot water to Infants' room.
Lydford C.P.	Drinking fountain.
Plymstock Hooe Infants	Drinking fountain.
St. Mary Tavy C.P.	Renew urinal. Provide heating to cloakrooms.
Shaugh Prior C.P.	Frost proof boys' toilets.
Wembury C.P.	New urinal.
Whitchurch C.P.	Drinking fountain.
Yealmpton C.P.	Renew urinal. Frost proof toilet.
Aveton Gifford C. of E.	Fluorescent lighting in small classrooms. Hot water supply.
Salcombe Infants	Drinking fountain. Hot water supply.
Salcombe Boys	Hot water supply. Drinking fountain.
Sparkwell C. of E.	Renew urinal.
West Alvington C. of E.	Additional wash basins and hot water supply.
Paignton, Hayes Road	Roof to boys' toilets.
Torquay, Ellacombe C.P.	Drinking fountain. Improve lighting in room 2.
Torquay, Homelands Infants	Renew wash basins.
Torquay, Sherwell Valley Junior	Enlarge boys' toilet and install 2 showers.
Brixham C. of E. Infants	Improve heating in Classromo I.
Torquay, Ilsham	Washbasin in infants' cloakroom.
Barnstaple, Ashleigh Road	Wash basins in girls' toilet.
Barnstaple, Cyprus Terrace	Additional heating in small classroom.
Bideford, East-the-Water	Enclose toilets.
Bratton Fleming	Complete frost proofing of toilets.

Filleigh C.P.	2 new washbasins.
	Hot water supply to children's and staff cloakrooms.
Great Torrington C.P.	Enclose toilets.
Hartland C.P.	Frost precautions.
	Improved water supply.
Horwood and Newton Tracey	Renew urinal.
	Provision of staff toilet.
	Washbasin in school.
Langtree C.P.	Widen entrance for Dental Unit.
Marwood C.P.	Enclose girls' toilets.
	Electric heating in classroom.
North Molton C.P.	Frost proof toilets.
	Additional staff toilet.
Parkham	Hot water supply to cloakrooms.
	Drinking fountain.
Umberleigh C.P.	Hot water supply to staff toilet.
Barnstaple St., Marys	Frost proof toilets.
	Provide heating to cloakrooms.
Bideford Junior C. of E.	Drinking fountain.
Parracombe	Hot water supply to cloakrooms.
	Frost proof boys' toilets.
South Molton United	Provide M. I. room.
Tiverton, Heathcoat C. Jnr.	Ventilation of boiler house.
Ashburton C.P.	Improvements to Staff room.
Axminster C.Sec.	Changing accommodation and showers for P.E. staff.
Barnstaple Grammar	Improvement to heating.
Bovery Tracey C.P.	Improvements to toilets, staff room, etc.
Buckfastleigh C.P.	Modernise lavatory accommodation.
Copplestone C.P.	M.I./Staffroom and staff lavatory.
Crediton Grammar	Improvements to Boarding House accommodation.

Minor Improvements (continued)

Secondary Schools

Newton Abbot Girls	Heaters in Science room.
Bampton C.S.	Ventilation of boiler house.
Crediton, Q.E. Grammar	Improvement to Staff changing facilities.
Okehampton Grammar	Renew urinal and flushing apparatus.
	Renew W.C. pans and cisterns.
	Hot water to Caretaker's room.
	Fluorescent lighting to laboratories.
Teignmouth Grammar	Improvements to changing accommodation for P.E. staff.
Broadclyst C.Sec.	2 drinking fountains.
Chagford C.Sec.	Extractor fan in boiler house.
Cullompton C.Sec.	2 drinking fountains.
Exmouth Boys' C.Sec.	Drinking fountain near tennis court.
Kingsteignton C.Sec.	Extractor fans in showers.
Teignmouth C.Sec.	M.I. Room.
	Roof to boys' and girls toilets.
	Staff toilet accommodation.
Kingsbridge School (Snr. Dept.)	Renew lavatory for Male staff.
	Enclose boys' lavatories.

Torquay Boys' Grammar	Hot water to basins in boys' toilets.
Torquay, Homelands Tech.	Shower for P.E. staff.
Dartmouth C.Sec.	Drinking fountain.
	Drinking fountain at Ford Bank Annexe.
	Fluorescent lighting at Ford Bank Annexe.
Torquay, Audley Park Girls	Drinking fountain.
Torquay, Westhill C.Sec.	Water heater and sink in lower school staffroom.
	Extractor fan for D.S. room.
	Footbaths in shower.
	Extractor fan and drinking fountain in gymnasium changing room.
Braunton C.Sec.	Improvement to staff toilets.
Chulmleigh C.Sec.	Improvement to staff cloaks and toilets.
	Hot water in H/M.s cloakrooms.
Crediton, Haywards C.P.	Lavatory improvements.
Diptford Parochial	Lavatory improvements.
Dunsford C.P.	Lavatory improvements.
Hartland C.P.	Lavatory imrpovements.
South Brent C.P.	Modernise infants' lavatories.
Teignmouth Grammar	New cloakrooms.
Torquay, Sherwell Valley Juniors	Additional showers.
Totnes, King Edward VI	Toilets for girls.
Totnes Girls' High	Provide lavatories for boys and male staff.
	M.I. room.

MENTALLY HANDICAPPED CHILDREN

We now have over 200 children attending training centres in the county, two centres being officially "overcrowded", and the numbers requiring places will increase. There are only a few mentally handicapped children between 5 and 16 years who do not attend any centre or other institution. These children may be too severely handicapped for them to be admitted to the training centres, or their parents may be reluctant for them to attend. A few parents would allow their children to attend daily, but refuse a boarding place. However, the distance would be too great for daily travel, Powers given under the 1959 mental health act to compel parents to allow their child's attendance have not yet been used.

Ascertainment

Formal ascertainment of the children as unsuitable for education in school can cause great distress to parents of mentally handicapped children. Many feel that this ascertainment is final and irrevocable in spite of careful explanations to the contrary, and therefore, informal placement with later review is being used more frequently to allay anxieties. Educational psychologists visit the centres regularly and the review of children is undertaken to see whether a child can profit from education in school. It is imperative that the interchange of children between school and centre be facilitated.

During 1966 several children were re-ascertained as educationally sub-normal, and left the centre to attend special schools.

JUNIOR TRAINING CENTRES

There are four of these in the county:

	Day Pupil Places	Residential Places
Abbeyfield, Abbey Road, Barnstaple	60	*28
Mayfield, Torquay Road, Paignton	48	—
Oaklands Park, Dawlish	48	43
Downham, Horn Lane, Plymstock	60	*22

* Weekly hostels.

From this it can be seen the provision is made for 216 places, 43 of which are fully residential and 52 for weekly boarders.

Staff

The staff/pupil ratio remains at 1 : 12 children.

The admission of children of 5 or under to the Centres means that many are not yet toilet trained and during the year an infant helper has been appointed at each centre to free the teacher from toilet training the children.

The policy of sending any untrained staff for full-time training continues. Untrained teaching staff are recruited only on the understanding that they are prepared to take a course and we hope that ultimately all staff will be trained.

Two new nursery class teachers have been appointed during the year. One is a trained nursery nurse, the other is S.R.N. We would like to have at least one male teacher at each centre but recruitment of suitable staff is difficult.

Accommodation

With increasing numbers, the centres are becoming overcrowded and extensions are being built at Downham and Mayfield. Besides extra classrooms, more space is needed for dining and teaching crafts.

Curriculum

Great advances are being made in the understanding of the learning processes and abilities of the mentally handicapped child. The staff of the four training centres are all keen to try any method which will help the children, in this rapidly developing field of child care.

The children are being taught (albeit slowly) along the lines of the nursery and infant schools' curriculum–each one encouraged to use his abilities to the limit; to experiment and to create.

Some older children after completing a pre-reading course, are able to read a little. All children are trained to recognise words important to daily living, e.g. "Danger", "Bus-Stop", Ladies", Gentlemen".

Social training is given emphasis, being recognised as the most important factor in community acceptance. Many children are socially almost as well developed as the normal child, in spite of their low intellectual development. Children are encouraged to widen their general knowledge and interests, and to become as independent and salf-assured as possible.

Health

The general health of children remains excellent apart from the usual childish ailments. Daily attending children have up to an hour's journey twice a day to attend the centre—which makes a long day for them—yet they thrive.

Many children at the training centres have other handicaps besides menta. subnormality, but are quickly accepted and absorbed into the community. It is rare for a child not to "settle" at the centres or the hostels. If he comes from a home where he is loved and accepted for what he is, there are few difficulties.

School Medical officers visit the centres regularly for medical inspections and take a great interest in the children and the centres.

Residential Inservice Training

In October 1966 a weekend course was held at Abbeyfield hostel for teaching staff of the four training centres. It was extremely well supported, and proved very successful. We were fortunate in having excellent speakers, several of whom were members of the staff of the Education Department. The programme is appended.

Teachers from the four centres were able to get to know each other and informal discussion was lively. It was agreed that a course such as this should be held regularly, and it is hoped that a further course can be arranged in 1968.

The staff at Abbeyfield hostel worked extremely hard to make the domestic arrangements a success, and their efforts were much appreciated.

Programme

Friday evening.	Talk. "Recent Developments in Training Methods for the Mentally Handicapped" by B. H. Flanders, Esq., Principal Tutor, Course for Teachers of the Mentally Handicapped, Leeds College of Commerce.
Saturday.	Talk. "Teaching Music to Mentally Subnormal Children" by J. Hollingsworth, Esq., County Music Adviser. Talk. "Suitable Methods of using Speech and Drama with Mentally Subnormal Children" by D. Bowskill, Esq., County Drama Adviser. Talk. "Teaching Craft to Mentally Subnormal Children" by Miss M. Clarke, Infants Schools Adviser. Talk. "Learning Processes in the Mentally Subnormal". Talk. "Preparing the Mentally Subnormal Child for Adult Life", Dr. J. Theobald, Senior Medical Officer for Adult Health, Devon County Council. Film Session. Miss P. Davies, Health Education Officer, Devon County Council.
Sunday.	Talk. "Helping Mentally Subnormal Children with their Speech", by Miss S. Fisher, Senior Speech Therapist, Devon County Council. Mrs. Crowe, head teacher of a junior training centre, gave her impressions gained from a conference of head teachers held at Manchester University in April 1966. Discussion and evaluation session.

Patent Teacher Association

All the centres have an active P.T.A. and a wide circle of friends, who contribute most generously to provide amenities for the children which are outside the scope of a local authority budget. By their efforts the three centres with hostel places have been provided with swimming pools and at Mayfield daily centre a paddling pool is planned.

Special Care Unit

The building of this Unit at Mayfield for physically and mentally handicapped children started in the summer and it is hoped that building will be completed by April 1967. The capital cost has been most generously donated by The Spastics Society.

This Unit will ultimately have day places for 10 children, who will be cared for and trained by a staff of three.

Escorts

It was agreed that escorts should be provided in all cars transporting children to and from centres. The possibilities of illness in a child or driver, of a sudden and precipitant action by a child, or of mechanical breakdown of the car, all placed too great a responsibility on a driver.

This year the financial situation has not allowed for this provision in all cars.

Westward T.V. film: "So Many Children"

The head teacher of Downham Junior Training Centre reports:

"Downham children have become rather blasé about meeting the general public, and entered into their new role as film stars with a natural and easy grace. The film was born out of an idea by John Pett the well-known interviewer of Westward Television, when he opened a Garden Fete in aid of the school swimming pool. This charming man was immensely attracted to the children and talked to them and their parents with genuine interest. Television time is however, valuable and it was two years before the seed could bear fruit.

"Five minutes was the original time planned for the film on 'Westward Diary'. This was later extended to twenty minutes for an 'Outlook West' programme, but the producer and technicians had by that time become so involved with the activities in the centre they were reluctant to cut any film at all. The finished article emerged as a full length documentary film of 45 minutes, at the peak showing time of 9.25 p.m.

"Written permission had first to be sought from each parent and only one refused. The County Medical Officer vetted the film but made no cuts.

"I had previously taken part in a script conference where the producer admitted he knew very little about his subject, and was prepared to play it 'off the cuff'.

"From the beginning I gained the impression from the whole crew, of absolute dedication. Nothing was too much trouble and they were really interested in the children and our methods of training.

"Filming began in the nursery unit where the apparatus, much of it designed and made by the staff, was being used by the children while I commented on its use and intention.

"John Pett fired impromptu questions at me which I found difficult to answer with the children all clamouring around me, and I felt rather anxious about the subsequent quality of the recording, particularly when I learned that the interviewer's questions were later to be deleted. I anticipated that the remaining commentary would sound disjointed and scrappy.

"The only preparation we made in the classrooms was to have equipment on hand in order to save time for the camera crew, I gave about five minutes advance notice to the teacher of the class.

"The actual filming created surprisingly little disorganisation in the centre, although the children were intrigued by the brilliant lighting on the first morning.

"Domestic science went ahead as usual, the crew selecting their 'targets' as they wished.

"The children were not posed for filming other than by being given simple instructions.

"We would like to feel that this came out in the film and the spontaneity recognised.

"There were many funny moments. For instance, the producer discovered he had filmed but not recorded children greeting the staff at the school door in the morning. To save time, I suggested staff might do this when the children went home in the evening. We prepared the children beforehand by explaining exactly what was needed, and though there were many giggles, the children were highly delighted to say 'Good morning, Miss' instead of 'Good night', on leaving. They entered into the spirit of it and thought it a huge joke.

"On the whole, staff felt the film was fairly comprehensive of a day at the centre, although our senior teacher with a class of children ten to fifteen years found very little time was left her, to film the result of three classes of training, and her group came off worst for filming time.

"The producer was eager to seek our opinion and suggestions, but of course he leaned towards the human angle, and we suspected that a physically handicapped child was over emphasised, in order that the producer could put over the point of 'something for everyone at Downham'. Recordings were made made of the views of a cross-section of our parents. and these were selected to pinpoint the specific difficulties in coping with different types of children, e.g. mongol twins, hyperkinetic, deaf, etc., etc.

"I was not present at these recordings but listened to, and afterwards requested a tape of the recording, as I felt that the staff at school should know the other side of the problem.

"When 'So Many Children' was televised, many congratulatory letters were received by the Westward I.T.V. studios, and press comments were flattering with the exception of one viewer with '24 years with the mentally handicapped behind her' expressed disapproval on the showing of our children's faces—quote: 'even prisoners have their faces covered'. We felt her 24 years' work must have been on a treadmill as her views had not progressed very far. Members of Downham Parent Teacher Association were straining at the leash to retaliate, but we felt the writer had adequately answered herself.

" 'So Many Children' has since been sold to the National network and we at Downham hope it will be viewed and enjoyed by a wider audience."

Dental Inspection and Treatment

All children in the centres were inspected. The number found to require treatment was less than last year and there was consequently a reduction in the amount of work done under most headings. During the year three children were referred for in-patient treatment in hospital.

Number inspected	202	Scaling and/or gum treatment	33
Number needing treatment	100	Fillings	110
Number treated	77	Silver Nitrate treatment	14
Number made dentally fit	50	Extractions	49
Attendances	105	General Anaesthetics	4
		Local Anaesthetics	35

BASILDON CHILDREN'S HOME, EXMOUTH

This is a local health authority children's home for convalescent children admitted on the recommendation of G.P.s and medical officers. In 1965 it was decided to also admit socially and emotionally deprived children, and as a result the home has been filled to capacity with a waiting list for admission. Admissions for 1966 totalled 63. This is a reduction on the previous year's admissions due mainly to an outbreak of chicken-pox in October, necessitating the cessation of admissions for a period of six weeks.

There is no doubt of the value of a recuperative holiday for the children; they quickly respond to the regular hours, good food, and fresh air. There is a large garden, and each season Basildon has its own hut on the beach nearby.

The children usually stay from 1–3 months. Girls are admitted from the age of 2–15 years, boys from 2–11 years. Basildon has occasionally been used for the care of a physically or mentally handicapped child with excellent results.

SPECIAL FAMILIES

The key worker with these families is of course the health visitor, but *par excellence* this is the field in which she needs to have a good working relationship with her colleagues. The bulk of co-ordinating committee work is decentralised to the field officers, and we have been more than justified by the excellent way in which they have handled matters. Whoever convenes the local meeting takes the chair, and is responsible for submitting reports to central office. Members of other services, for example Probation, N.S.P.C.C., may be invited as appropriate.

Any health visitor who wishes to have further guidance about a family can contact Miss McGilvray, a group adviser with special responsibility for these families throughout the county; she goes out to the health visitor and usually visits the family also. The senior medical officer is kept informed by Miss McGilvray and, if any officer feels a co-ordinating meeting should take place at central level, request is made to a member of the education department, who convenes these, and he is informed of the circumstances.

The following figures give the measure of the work. The "others in" the first group are those on whom a close watch is kept but who are, for the moment, keeping their heads above water: in the second, potential, group the "current" ones are those recently reported as possible breakdowns should some outside factor upset the equilibrium, and on whom we therefore keep a watchful eye and try to reinforce weak points: the "others" are one place removed again, and least likely of all to break down, but as this service aims at prevention as well as alleviation, we ask for all such families to be reported.

Basildon, our convalescent home at Exmouth, has proved an effective means of preventing a family break-up, as well as providing the children with a chance to build up their low resistance.

SPECIAL FAMILIES 1966

Current	138
Others	235
Total	373

POTENTIAL SPECIAL FAMILIES 1966

Current	180
Others	247
Total	427

CO-ORDINATING MEETINGS 1966
28
CHILDREN FROM SPECIAL FAMILIES IN BASILDON
1966 .. 14 families, 35 children

LIAISON WITH OTHER DEPARTMENTS

The senior medical officer for the child health section is the official liaison officer, but co-operation is close at all levels, and the development of the local co-ordinating meetings as described in the section on special families has made this even more effective.

In addition, Miss McGilvray attends the children's department case conference at Villa Languard once a month. This is a reception home and the conference occasion is most valuable both from the point of view of getting to know the child care staff who attend to report on progress in planning for children from their areas, and because many of the children are already known to the health department as members of a special family. The link is extremely important when a child is discharged from the home, as the health visitor can be alerted in the receiving area. Dr. Epstein, is medical officer to Villa Languard and she gives expert advice on health matters both in the particular and in the broadest social sense of health education.

The children's officer keeps the health department up to date on children's department matters by sending us copies of relevant minutes and, in particular we are most grateful for the copies of the minutes of area children's officers' meetings.

Liaison with the Welfare Department is mainly at field level but Miss McGilvray and Miss Williams, Deputy Welfare Officer, have developed an excellent understanding in relation to the care of problem families and also in the training of new staff who are given an insight into the work of the Health Department. This is extremely important because it is ignorance of one another's distinctive function which causes difficulties among the field workers, particularly when areas of responsibility overlap as much as they do between health and welfare departments.

The understanding and co-operation invariably offered by the administrative staff of the education department is very much appreciated. This team work is vital if the school health service is to run smoothly.

DAY NURSERIES AND CHILD MINDERS

	1965	1966
Nurseries		
Number on register, 31st December	36	50
Permitted number of children at these nurseries	796	1,096
New registrations	17	17
Cancellations	6	3

Child Minders

Number on register, 31st December	40	67
Permitted number of children	370	605
New registrations	14	32
Cancellations	4	5

Throughout the country numerous playgroups are being formed. This can be seen to apply to Devon where most of the new registrations in 1966 were in order to start playgroups.

Before registration is granted by the Child Health Committee the applicant and the proposed premises are visited by one of the medical staff, and in the case of a Day Nursery by a fire prevention officer. Advice is given as required on all aspects of child care. It is realised that the mental health, as well as the physical health, of the children who attend should be considered, and that the play facilities and the approach of the staff to the children are important.

Applicants are given names and addresses of voluntary organisations which will stimulate their interest in the work they are proposing to do.

After registration has been granted the assistant medical officer and the health visitor of the district are notified. Each nursery and child minder is visited at least three times a year by the health visitor and often more frequently. Medical Officers also visit.

Many of the people who are registered child minders or who staff the day nurseries have a qualification such as nursing, nursery nursing or teaching and nearly all have had children of their own. The majority are very enthusiastic about the work they do and are most anxious to do it well.

In April 1965, the Ministry of Health issued a circular on the Day Care of Children. It emphasised the need for registration of Nurseries and Child Minders to safeguard the health and welfare of the children, and mentioned that extra training for people who look after children is useful.

Many playgroup staff have expressed a wish to learn more about their job. As a start a Day's Course was held at County Hall on Saturday, 21st May and invitations were sent to all child minders and representatives of each day nursery. 180 attended. During the day there were talks, discussion and a film. There was an exhibition of equipment for play-groups. Morning coffee, lunch and tea were provided, so that playgroup staff had an opportunity to meet and talk to others who were doing similar work.

The course was a success and plans went ahead to provide more courses in 1967.

In Devon the health problems connected with nurseries and child minders are few. The greater need is to educate playgroup staff to educate the children. We are most fortunate in having the help and advice of the Education Department who helped to arrange the day's course and who have agreed to help with the courses in 1967.

THE SCHOOL DENTAL SERVICE

Mr. J. D. Sykes, the Chief School Dental Officer, reports:

Staff

At the beginning of the year there were vacancies at Crediton and Totnes though appointments had been made and Miss Kathleen Billings and Mr.

G. W. B. Bateman both started work in January. In the same month Mr. V. G. Holdsworth, the dental officer at Paignton, died suddenly on arriving home after a normal day's work. He had been a member of the full-time staff for only two years after assisting in a part-time capacity for several periods during many preceding years. We regret the loss of a charming and kindly colleague. He was replaced by Mr. Hobdell, at first in a part-time capacity and assuming full-time duties in May. The bold decision to advertise the orthodontist post at a salary comparable with similar posts in the hospital service was immediately fruitful and Mr. J. D. W. Barnett took up his appointment on 1st May. A few days later when Mrs. Kadzielska reported for duty the writer found himself for the first time since initially appointed Chief Dental Officer in 1942 with a full staff. In November, Mr. J. Smith resigned to return to general practice and Mr. G. H. S. Clarke retired at the end of the year at which time there was no prospect of replacing either. Mr. W. J. Littleton who had worked part-time at Newton Abbot during Mr. Steer's illness earlier in the year worked part-time at Barnstaple in December. When Miss Williams replaced Miss Sowden in September she was the fourth dental auxiliary to occupy this post since the scheme started in October 1962.

Clinics and Equipment

Last year this paragraph reported that "this has been the best year's progress yet reported under this heading". Apart from the addition of minor items under the routine re-equipment programme there is no progress at all to report for 1966. The opportunity is taken, therefore, to look at the progress over twenty years. In 1944 the county had absorbed the "Part III" Authorities Barnstaple, Tiverton and Torquay together with their staff and clinic premises. There were then six equipped clinics only one of which was purpose-built, the others being converted domestic premises. Twenty years later there are nine purpose-built clinics and ten clinics in converted premises. In addition there are ten equipped mobile clinics. All have air-turbine equipment and two mobile and fifteen static clinics have X-ray equipment. All the static clinics are equipped for the administration of general anaesthetics. In 1945, apart from two officers in the Torquay Clinics, the staff were providing treatment by the use of a portable kit and all but four of them had no other means of doing so. This kit consisted of a folding chair with a hand spittoon attached and a foot-pedalled dental engine. For some obscure reason the dentist calls his drill "a dental engine" whether operated by foot or by electricity. The sterilizer was heated over a spirit lamp and the instrument table was often a desk or blackboard covered with towels. The method of treatment is still in use by five members of staff in a small number of schools. This number of schools has been steadily reduced as the number of mobile clinics increased. With universal access to electricity the portable equipment has been improved and now includes engine, air turbine high speed drill, operating light, sterilizer and suction unit all operating from mains electricity. Good and valuable treatment has been provided in the past by these means but often the conditions under which the treatment is given are not satisfactory. In 1944 the Chief Dental Officer in his report said ". . . it may here be stated that not only is it necessary that good work should be done but also that it should appear to an onlooker to be done; that is to say it should be done under conditions sufficiently impressive to convince parents that their children are receiving the best possible treatment".

In 1947 the report listed ten clinics urgently required. All are now functioning. It is also suggested that "the necessity for clinics at Sidmouth, Dawlish and Teignmouth cannot be overlooked". Whilst these three clinics do not exist they have not been overlooked and plans are at various stages of development.

The replacement of the clinics at Totnes and Crediton is no nearer. Of the former Mr. Bateman says "the building . . . is quite unsuitable and is moreover liable to flooding during heavy rains. The surgery offers inadequate space; indeed the dental chair has to be placed at an angle to the window to allow the dental surgeon and surgery assistant to move around it". Equipment and stores both suffer from the perpetual dampness. Crediton clinic is a much more spacious and cheerful place and there by contrast the dampness comes from above as a result of leaks in the roof. The floor sags and all the equipment leans towards, fortunately, and not away from, the operator. With the increase in cytology and chiropody the clinic at Dartmouth is quite inadequate. The accommodation does not allow of much convenient joint usage. During most of the year Mr. Vowles works in the clinic on two Fridays only in each month. When, however, he is working in the Dartmouth Schools he needs much more weekly time than this if the treatment of the schools is not to drag out an inordinately long time. As each visit to the clinic means getting out and putting away the equipment once and packing and unpacking his kit of instruments, materials and linen twice it is obviously desirable to keep the frequency of this exercise to a minimum.

The dropping of the proposal to build an extension to the premises at 97 Heavitree Road in Exeter was a serious set-back to the development of the dental service. A County centre for the orthodontic service and a base clinic for the Exeter Area are essential. There are ten major roads converging on Exeter, the natural transport centre for a considerable County area. Patients living near find it hard to understand why they are given appointments at places such as Okehampton, Tiverton or Honiton, as has to be done when X-rays are required. This problem will shortly become worse still as the facilities for the treatment of emergencies which we do have at present at the Royal Devon and Exeter Hospital may be withdrawn at any time.

Health Centres

There are now in operation the first of the health centres in which general medical practitioners are under the same roof as the County health staff. Mr. Shipley at Okehampton notes that "Dr. Jones and Dr. Twining have continued to offer their services as anaesthetists when required and I would like to express my thanks to them for their co-operation which occasionally has been at very short notice" which, of course, they are more easily able to do when working in the same building. It has been suggested that provision should also be made for the general dental service in the health centres, but different considerations apply. The general medical practitioner and the authority's doctors and nurses are providing different services for the same patients. The general dental practitioner and the County dental staff are providing the same service for different patients. In the one case the services are complementary, in the other they are, dare one use the word, competitive. This latter factor might lead to difficulties, particularly in a centre not staffed full-time by both services, as would be the case in most health centres to be built in this County.

Mobile Dental Clinics

A further Mobile Clinic was delivered during the year and it has recently been found not so difficult to arrange a reasonable allocation programme. There are, however, many schools not on the visiting list. To include them and to allow the vehicles to be brought in periodically for servicing the fleet will have to be enlarged still further and by the time this is achieved some of the earlier vehicles will be due for replacement. The two oldest were introduced in 1953 with a working life expectancy of 10 years.

On the subject of the extended use of mobile clinics Mr. Vowles says, "It can be argued that the use of the caravan to treat small schools is uneconomic. The alternatives in my area are not all that attractive. The use of portable equipment in a classroom is the most prevalent. The big drawback to this is that two classes have to be held in one classroom. This, of course, is not particularly popular with the teachers affected". This problem diminishes as the visiting list is enlarged. But the outstanding schools are now predominantly the small ones where economic considerations have to be taken into account. Where the clinic is not taken to a school because the small amount of work does not justify it, or because physical features deny access to the precincts of the school—there are places where the clinic cannot even be got into the village—then the children are transported for treatment to the next nearest school where it can be sited.

Inspection and Treatment

Most officers are getting around their areas in a year and some are able to get in two routine inspections within the year in some of their primary schools. This obviously indicates inequality of load. The dental 'Areas' have been unaltered for many years and shifts of population, closure of old and opening of new schools have contributed to this imbalance and the distribution of G.D.S. practitioners also affects the situation. Alteration of the Areas has been delayed so that any adjustments necessitated by County Boundary changes could be dealt with at the same time. The new dental 'Areas' adopted on 1st January, 1967 are designed so that the new Plymouth and Torbay boundaries and the Area boundaries run together to simplify detachment on the appointed dates. It is hoped that the work loads in the Areas will have been equalised to some extent next year, but some inequality must be accepted as the size and shape of the Area is dictated to a considerable extent by the position of the Base Clinic and by the transport facilities of the region.

The first of the Boundary changes became effective on 1st April when Mr. Dickson lost Alphington and Pinhoe Schools and Mr. Pomeroy lost Topsham School all to Exeter City.

The Histogram page 163 and the graph page 164 show at a glance that there have been only minor changes in the number of children inspected and treated and in the amount and nature of the work done compared with last year. What changes there have been continue the trends noted in recent years. It is seen that 20 years ago 80% of children found to require treatment received it under the school service whilst now only 50% do so. Treatment has not been offered to all of the other 50%. Amongst them are many who whilst in need of treatment at the time of inspection are obviously under regular treatment elsewhere. No invitation for treatment is issued to these. There are others who bring letters at routine inspection stating that they "have their own private dentist" though there is often no evidence in the mouth to support such a statement. Altogether about 20% of the number recorded as needing treatment are not offered it for one reason or another.

The fact that 50% of children are found not to require treatment would seem to indicate a reasonably satisfactory state of affairs. They do not need treatment only because they have just had it. The survey of school leavers quoted last year showed that only one child out of 500 reached the age of 15 years without requiring some dental treatment.

FIG. 1

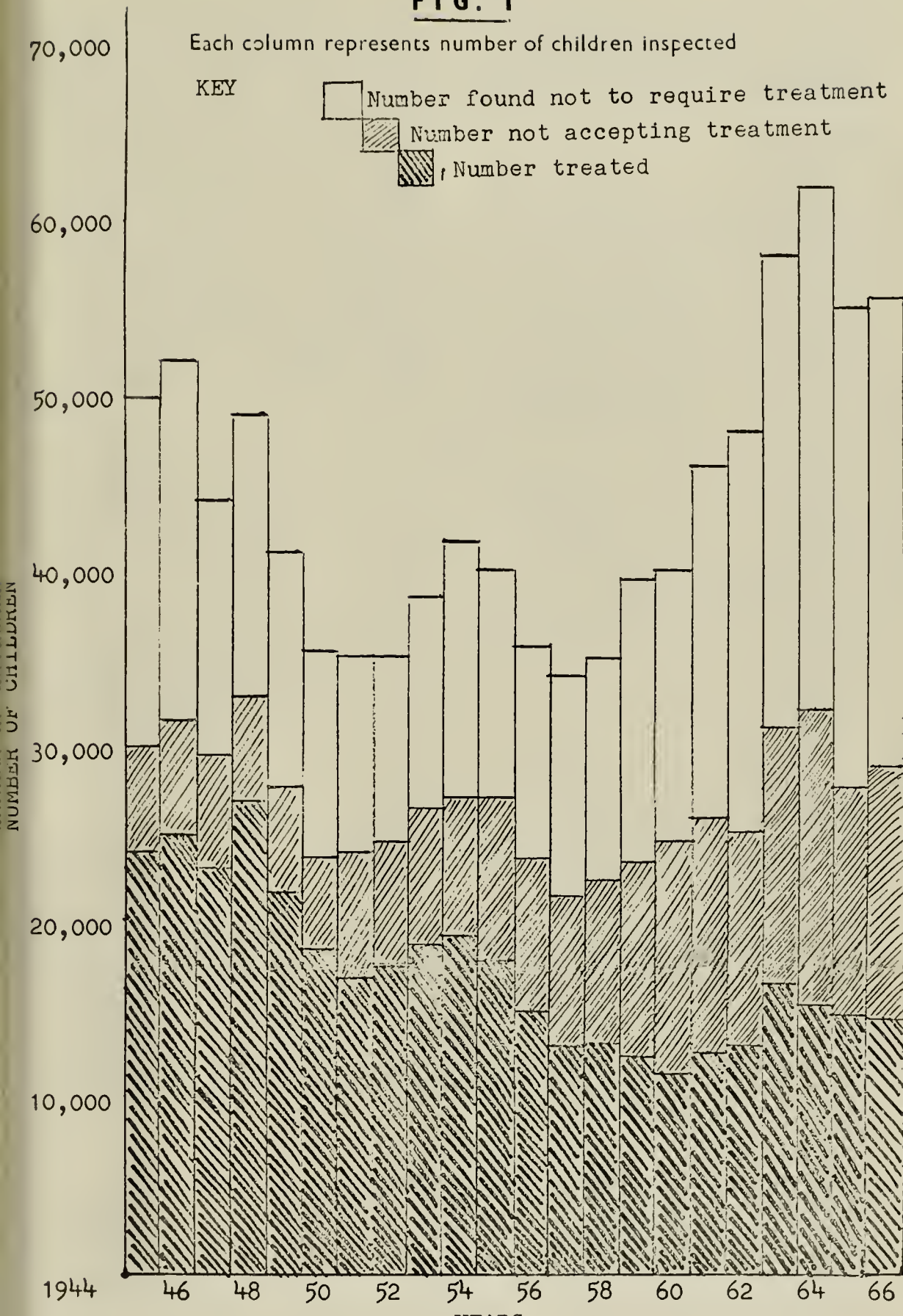
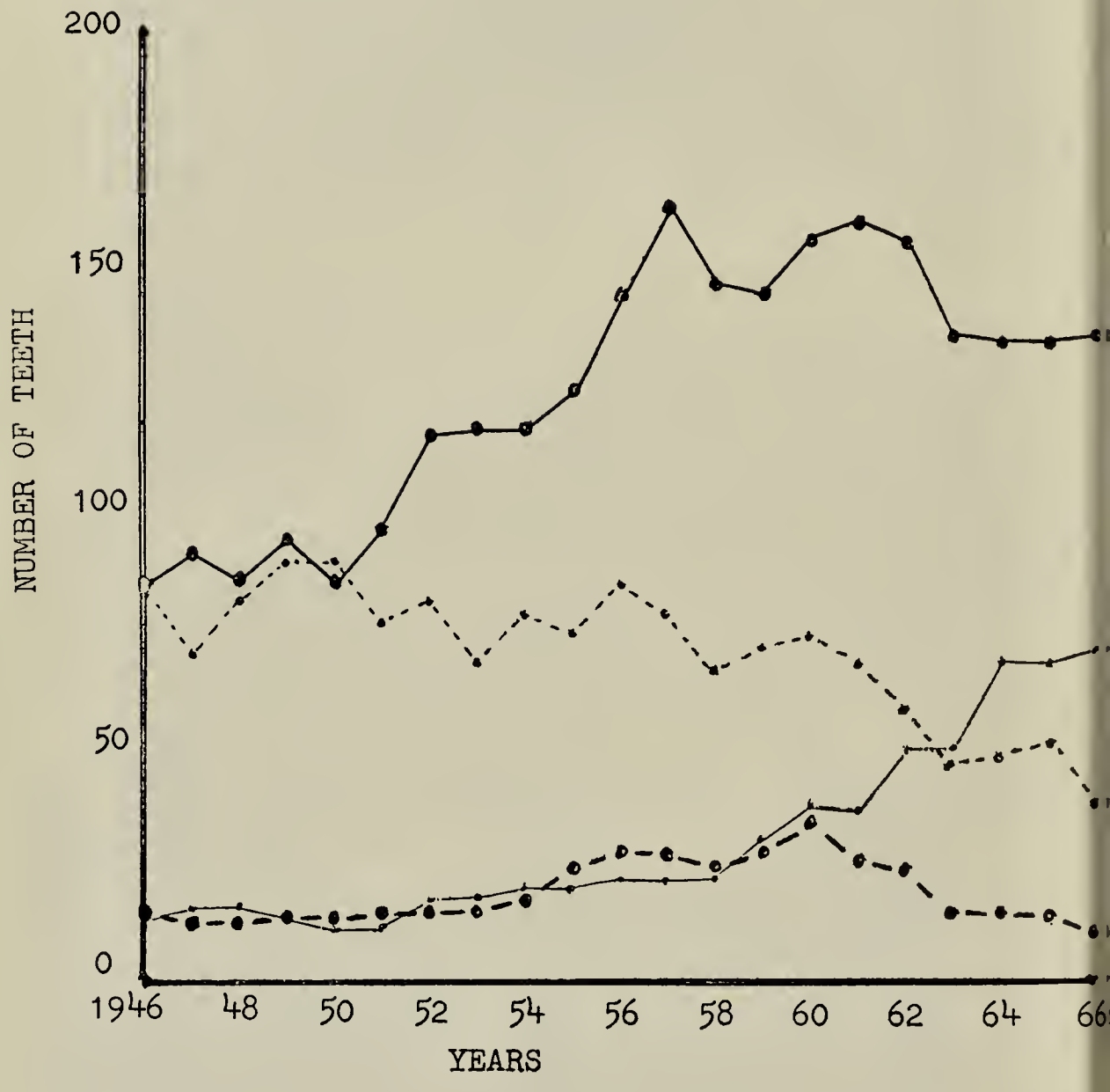

Each column represents number of children inspected
KEY
Number found not to require treatment
Number not accepting treatment
Number treated
70,000
60,000
50,000
40,000
30,000
20,000
10,000
1944
46
48
50
52
54
56
58
60
62
64
66
YEARS
NUMBER OF CHILDREN

FIG. 2

Details of Dental Treatment per 100 Children treated



KEY: Permanent teeth filled
Permanent teeth extracted
Temporary teeth filled
Temporary teeth extracted

ATTENDANCE AND TREATMENT

First Visit	14872
Subsequent Visits	21442
Total Visits	36314
Additional courses of treatment commenced	1552
Fillings in permanent teeth	23121
Fillings in deciduous teeth	11307
Permanent teeth filled	20372
Deciduous teeth filled	10458
Permanent teeth extracted	1533
Deciduous teeth extracted	5608
General anaesthetics	1541
Emergencies	820

PROSTHETICS

Pupils supplied with F.U. or F.L. (first time)	1
Pupils supplied with other dentures (first time)	41
Number of dentures supplied	49

INSPECTIONS

(a) First inspection at school. Number of pupils	51944
(b) First Inspection at clinic. Number of Pupils	5405
Number of (a)+(b) found to require treatment	28347
Number of (a)+(b) offered treatment	21292
(c) Pupils re-inspected at school or clinic	4577
Number of (c) found to require treatment	2837

ANAESTHETICS

General Anaesthetics administered by Dental Officers	1237

ORTHODONTICS

Cases remaining from previous year	414
New cases commenced during year	183
Cases completed during year	160
Cases discontinued during year	22
No. of removable appliances fitted	280
No. of fixed appliances fitted	12
Pupils referred to Hospital Consultant	37
Number of Pupils X-rayed	987
Prophylaxia	4497
Teeth otherwise conserved	2539
Number of teeth root filled	41
Inlays	32
Crowns	34
Courses of treatment completed	14381

SESSIONS

Sessions devoted to treatment	7107
Sessions devoted to inspection	772
Sessions devoted to Dental Health Education	434

As always there are many cases turn up during the year which cannot be considered routine. Some of these are dealt with by the dental officers themselves. There are others, however, which for medical or surgical reasons cannot be treated in the clinics and these are referred to hospital. Again our thanks are due to Mr. P. A. Bramley and Mr. P. H. D. Lewars the consultant dental surgeons in Plymouth and Exeter for their ready acceptance of these cases and for the informative reports received after completion of treatment.

ORTHODONTICS

The one feature common to all the D.O.'s reports is the appreciation of the resumption of the Orthodontic Service. Mr. Barnett took over in May and because of earlier frequent staff changes and the transfer of cases "to and fro" between D.O. and temporary orthodontist what he found was inevitably some degree of chaos. He decided wisely to do a new assessment and documentation of every case on hand. A new record card-folder was designed compounding useful

features noted in the cards of other authorities and makes provision for holding safely together all X-rays and loose papers connected with the case. All this took time and only later in the year did the stream of treatment begin to flow again. In addition to the close liaison Mr. Barnett has with the dental officers in their own clinics, he also spends one session each month with Mr. Maurice Burley the Consultant to the R.H.B. when particularly difficult or complicated cases can be discussed and treatment plans formulated.

REFRESHER COURSES

Miss Billings attended a Course for Dental Officers in Dundee. She comments that whilst the subject matter of the lectures and classes is valuable in bringing one up to date in professional matters there is a bonus in the form of exchange of ideas and experience with colleagues from other authorities. Mr. Vowles write, "I was fortunate this year to be able to attend a short course on the treatment of handicapped children. This was held at the new Dental School in Cardiff. It was perhaps unfortunate that the course was such a short one; nevertheless it was most valuable and I should like to express my thanks for the opportunity to attend.

On this course and on a previous one I attended, emphasis was placed on the fact that diet played a much more important part in the control of caries than the normally accepted oral hygiene practices. With this in mind I would yet again put in a plea for the enlargement of the dental health education programme". It is unfortunate that our dental courses tend to be short 2–3 days which means a disproportionate cost in time and money spent travelling.

DENTAL HEALTH EDUCATION

Mr. Vowles plea in the last paragraph is echoed by many other dental officers. With the enthusiasm of Miss Turnage and the extension of her activities the staff are realising the value of this work, and a further dental hygienist should be appointed as soon as possible so that all the schools can be visited at least once a year. The hygienist's clinical training is, of course, wasted in this work and it would seem reasonable for the local authority itself to train a new type of ancillary specifically for this work. But why a special officer specifically for dental health education? With virtually 100 per cent of the school population in need of dental treatment, and fluoridation rejected special measures are undoubtedly required. Miss Turnage in her report says, "In the past year approximately 6,500 children have received dental health education in schools which have never before been visited. Teachers have been very impressed and anxious to help. Provision of raw apple or carrot after school meals is very spasmodic. Both the teachers and I would like to see this as general practice in schools and not just here and there. It is estimated that at the end of 1967 a system for revisits to all C.P. Schools in the County can be completed in an eighteen to twenty month schedule. This together with the help and present enthusiasm of the teachers will maintain a level of dental health amongst the children who now seem to be placing a greater value on the care of their teeth since receiving these lessons."

FLUORIDATION

On the 20th January this Authority like all the others in the West Country decided against fluoridation. That it should do so is surprising; that the majority against should be so large is astonishing, especially after the approval of the Health Committee. It now remains for those authorities who have adopted the measure to show the usual dental benefit and complete absence of any ill effects.

The City of Birmingham is one of these. Opposition, of course, has not died down nor will it for a long time.

CONCLUSION

The staff have asked me to express their thanks to various people for help and co-operation. The list makes one realise what a team effort this is. There is no significance in the order. Teachers and School Clerks, Medical Officers, Health Visitors, Clinic Clerks, Speech Therapists, General Medical Practitioners, Welfare Officers and staff at County Hall, not forgetting the Surgery Assistants.

MENTALLY HANDICAPPED CHILDREN

JUNIOR TRAINING CENTRES

Dental Inspection and Treatment

All children in the Centres were inspected. The number found to require treatment was less than last year and there was consequently a reduction in the amount of work done under most headings. During the year three children were referred for in-patient treatment in hospital.

Number inspected	202	Scaling and/or gum treatment	33
Number needing treatment	100	Fillings	110
Number treated	77	Silver nitrate treatment	14
Number made dentally fit	50	Extractions	49
Attendances	105	General anaesthetics	4
		Local anaesthetics	35

PART VIII

Particulars of Clinics etc.

as at 1-6-67

THIS LIST IS LIABLE TO ALTERATION WITHOUT NOTICE, ACCORDING TO THE DEMANDS OF THE SERVICE.

	Telephone Number	Child Welfare Centre	Ante-Natal Clinic	Cytology Clinic	Chiropody Clinic	Audiology Clinic	Speech Therapy Clinic	Ophthalmic Clinic	Dental Clinic	Child Guidance Clinic	Other Unspecified Clinics
APPLEDORE											
Hall, Newquay Street		*									
ASHBURTON											
St. John Ambulance Hall		*	*		*						
AXMINSTER											
Methodist Church Hall		*	*								
AXMINSTER											
District Hospital					*		*				
AXMINSTER											
Secondary School									*		
BAMPTON											
Public Hall					*						
BARNSTAPLE Clinic	5137										
Clinic, 19b Alexandra Road CG	3048	*	*	*	*	*	*	*	*	*	*
SW	4086										
BEER											
Congregational Hall					*						
BERE ALSTON											
3 Station Road					*						
BIDEFORD											
Parish Church Institute		*	*	*		*					
BIDEFORD											
Clinic, Coronation Road	3163				*		*	*	*		
BOVEY TRACEY											
Wickham Hall		*			*						
BOW											
Nurses Home, "Moorview"					*						
BRADNINCH											
Guildhall					*						
BRADWORTHY											
Memorial Hall					*						
BRANSCOMBE											
Village Hall					*						
BRATTON CLOVELLY Parish Hall					*						
BRAUNTON											
Parish Hall		*	*		*						
BRIXHAM											
Clinic, Greenswood Road	3374	*	*	*	*		*	*	*		
BROADCLYST											
County Primary School		*	*		*						
BROADCLYST											
County Secondary School							*				
BUCKFASTLEIGH											
Health Centre, Bossell Road	2171	*	*	*	*						
BUDLEIGH SALTERTON											
Church Institute		*	*								
BUDLEIGH SALTERTON											
1 Rock Mansions	2213				*						
BUDLEIGH SALTERTON											
Health Centre, 1 The Lawn											
BURLESCOMBE											
W.I. Hall					*						
CHAGFORD											
Jubilee Hall		*			*						
CHERITON BISHOP											
Village Hall					*						
CHUDLEIGH											
St. John Ambulance Hall		*									
CHUDLEIGH											
British Legion Hall					*						
COLYTON											
Methodist Hall					*						
COLYTON											
Youth Club		*									
COMBE MARTIN											
Town Hall		*			*						
CREDITON											
Clinic, "Newcombes"	2649	*	*	*			*	*	*		
CREDITON											
Bowden Hill					*						
CROYDE											
Village Hall					*						
CULLOMPTON											
Parish Rooms		*	*		*				*		
DARTMOUTH											
Clinic, Mayors Avenue	2845	*	*	*	*			*			

	Telephone Number	Child Welfare Centre	Ante-Natal Clinic	Cytology Clinic	Chiropody Clinic	Audiology Clinic	Speech Therapy Clinic	Ophthalmic Clinic	Dental Clinic	Child Guidance Clinic	Other Unspecified Clinics
DARMOUTH											
Baptist Church Hall		*									
DAWLISH											
Clinic, The Knowle	3254	*	*	*	*		*	*			
EXETER											
Alice Vlieland Centre, Bull Meadow Road						*		*			
EXMINSTER											
Victory Hall		*			*						
EXETER											
97 Heavitree Road	76348						*			*	
EXMOUTH											
Clinic, 89 Withycombe Village Road	2610	*	*	*	*	*	*	*	*		
FREMINGTON											
Parish Hall		*									
GEORGEHAM											
Village Institute					*						
HARTLAND											
W.I. Hall		*	*		*						
HATHERLEIGH											
26 South Street					*						
HARBERTON											
Village Hall			*								
HEMYOCK											
Church Hall					*						
HOLSWORTHY											
Town Hall		*	*	*	*			*			
HONITON											
Clinic, Northcote Lane	2252	*	*	*	*		*	*	*		
HOOSE—see TURNCHAPEL											
Church Hall		*									
HORRABRIDGE											
Methodist Church Room		*									
IDE											
Memorial Hall					*						
ILFRACOMBE											
Health Centre, Marlborough Road	3521	*	*	*	*	*	*	*	*		
SW	3527										
INSTOW											
4 Bath Terrace					*						
IPPLEPEN											
Health Centre	621	*			*						
IVYBRIDGE											
Methodist Church School Hall		*	*		*						
KENTON											
Nurses Bungalow					*						
KINGSBRIDGE											
Clinic, Fore Street	2606	*	*	*	*		*	*	*		
KINGSKERSWELL											
Public Hall		*			*						
KINSTEIGNTON											
Parish Church Hall		*									
KINGSTEIGNTON											
Rest Centre					*						
KINGSNYMPTON											
Church Hall					*						
KINGSWEAR											
Trust Rooms		*									
LEWDOWN											
The Victory Hall					*						
LIFTON											
Methodist Church Rooms		*									
LITTLEHAM											
Church Hall		*									
LUSTLEIGH											
The Old Vestry					*						
LYDFORD											
Nicholas Hall					*						
LYNTON											
Health Centre, Burvill Road	3226	*	*		*						
MARLDON											
Parish Hall					*						
MARLDON											
Old School		*	*								
MODBURY											
Memorial Hall		*			*						

	Telephone Number	Child Welfare Centre	Ante-Natal Clinic	Cytology Clinic	Chiropody Clinic	Audiology Clinic	Speech Therapy Clinic	Ophthalmic Clinic	Dental Clinic	Child Guidance Clinic	Other Unspecified Clinics
MORCHARD BISHOP											
Memorial Hall					*						
MORETONHAMPSTEAD											
Methodist Hall		*			*						
NEWTON ABBOT											
Clinic, 21 Courtenay Park	2445	*	*	*	*		*	*	*		
NEWTON POPPLEFORD											
Methodist School Room					*						
NORTHAM											
Church Hall		*			*						
NOSS MAYO											
Village Hall					*						
OKEHAMPTON											
Health Centre, Memorial Hospital Grounds	2231	*	*	*	*		*	*	*		
OTTERY ST. MARY											
Health Centre, Sandhill Street	2288	*			*		*				
PAIGNTON											
Clinic, Midvale Road	59131	*	*	*	*		*	*	*		
PAIGNTON											
Clinic, 37 Smallcombe Road	58194	*	*		*						
PARRACOMBE											
Buffaloes Hall					*						
PRESTON											
Baptist Hall		*									
PRINCETOWN											
Ladies Club Hall		*	*		*						
ROBOROUGH											
Recreation Hall		*									
ST. GILES-ON-THE-HEATH											
Coronation Hall					*						
SALCOMBE											
Methodist Hall		*	*								
SALCOMBE											
Baptist Hall					*						
SEATON											
Town Hall					*						
SEATON											
Women's Institute		*									
SHEBBEAR											
Church Rooms					*						
SIDFORD											
Reading Room		*									
SIDMOUTH											
Liberal Hall		*	*								
SIDMOUTH											
St. John Hall					*						
SIDMOUTH											
Secondary Modern School									*		
SOUTH BRENT											
Church Hall		*			*						
SOUTH MOLTON											
Clinic, 99 East Street	2352	*	*	*	*	*	*	*	*		
SPREYTON											
Village Hall					*						
STARCROSS											
Reading Room					*						
STICKLEPATH											
Village Hall					*						
STICKLEPATH											
Parish Hall		*									
STOKE CANON											
Jubilee Hall					*						
STOKE FLEMING											
Recreation Club					*						
STOKE GABRIEL											
Church Hall		*									
STOKE GABRIEL											
Village Hall					*						
STOKENHAM											
Parish Hall					*						
TAVISTOCK											
Clinic, Crowndale Road	2617	*	*	*		*		*	*		
TAVISTOCK											
Westbridge					*						
TEDBURN ST. MARY											
Pathfinder Caravans					*						

	Telephone Number	Child Welfare Centre	Ante-Natal Clinic	Cytology Clinic	Chiropody Clinic	Audiology Clinic	Speech Therapy Clinic	Ophthalmic Clinic	Dental Clinic	Child Guidance Clinic	Other Unspecified Clinics
TEIGNMOUTH											
St. James Room		*						*			
TEIGNMOUTH											
Gospel Hall					*						
TEIGNMOUTH											
2 Den Crescent			*								
THORVERTON											
Memorial Hall					*						
THURLESTONE											
Parish Hall					*						
TIVERTON											
Clinic St Andrew's Street	3341	*	*	*	*	*	*	*	*		
TORQUAY											
Castle Road	27963				*	*	*	*	*	*	
TORQUAY											
Barton School Clinic	37274 (Dental)	*			*				*		
TORQUAY											
Furrough Cross Congregational Church Hall		*									
TORQUAY											
Belgrave Congregational Church Hall		*									
TORQUAY											
Holy Innocents Church Hall		*									
TORQUAY											
Market Street Methodist Church Hall		*									
TORQUAY											
Shiphay New Church Hall		*			*						
TORQUAY											
Watcombe Community Centre											
TORQUAY											
25 Abbey Road					*						
TORRINGTON											
Church House		*	*		*			*			
TOTNES											
Rosabelle, Plymouth Road	2335				*			*			
TOTNES											
Borough Park Hut	2078	*	*					*	*		
TURNCHAPEL and HOOE											
Church Hall		*									
UFFCULME											
Ploat House					*						
WESTWARD HO!											
Chalet Private Home					*						
WILLAND											
Village Hall					*						
WINKLEIGH											
Village Hall					*						
WITHERIDGE											
Parish Hall					*						
WOODBURY											
Village Hall					*						
WOOLACOMBE											
Methodist Hall		*			*						
YEALMPTON											
Women's Institute Hall					*						
YEALMPTON											
Chapel Rooms		*	*								
YEALVERTON											
Church Hall					*						